

**Regulatory Jurisdiction Over
Health Insurance Products:
The Department of Managed Health Care
&
The Department of Insurance**

by

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November 26, 2001**

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Chapter I.

Executive Summary

The Department of Managed Health Care (“DMHC”) licenses and regulates health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended. Pursuant to Health & Safety Code § 1347, the Advisory Committee on Managed Health Care assists and advises the Director of DMHC in the implementation of the Director’s duties. Section 1342.3 of the Health & Safety Code requires that the Director, in conjunction with the Advisory Committee on Managed Care, undertake a study to consider the feasibility and benefit of consolidating into DMHC the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products that are currently regulated by the California Department of Insurance (“CDI”). The results of the study, along with the recommendations of the Director, are to be incorporated into a report to the Governor and the Legislature by no later than December 31, 2001.

The Regulatory Implementation and Structure Subcommittee of the Advisory Committee on Managed Health Care is charged with the implementation of the jurisdictional study mandated by Health & Safety Code Section § 1342.3. The Subcommittee retained the Capital Center for Government Law and Policy at the University of the Pacific McGeorge School of Law to prepare the jurisdictional study and to suggest options for consideration by the Subcommittee, the Committee and the Director.

The study begins with a brief overview of the historical development of health insurance regulation in California, which from the beginning has been a story of divided regulatory jurisdiction. During the early years, from the 1940s to the 1960s, jurisdiction over health insurance was divided between the Insurance Commissioner and the Attorney General. Beginning with passage of the Knox-Keene Act in 1975, jurisdiction was divided between the Insurance Commissioner and the Department of Corporations. Now, jurisdiction is divided between the Insurance Commissioner and the Department of Managed Health Care.

From a national perspective, the division of regulatory jurisdiction over health insurance and health care service plans is unusual. In about 40 states, there is a single primary regulator, and regulatory jurisdiction over all health insurance, including health care service plans, is vested in a department of insurance. In the few states

where jurisdiction is divided, a variety of devices have been employed to maintain regulatory consistency, ranging from statutory directors to memorandums of understanding between the regulators.

CDI, which is led by the independently elected Insurance Commissioner, is responsible for regulating the business of insurance in California, which consists of 26 different lines of insurance offered by some 1,400 qualified insurers, some of whom operate only domestically, but many of which operate nationally. CDI regulates health insurance pursuant to its statutory authority to regulate “disability insurance.” By statute, CDI is the primary regulator of all entities that are engaged in the business of health insurance except those entities subject to the jurisdiction of another government agency. Health care service plans are expressly exempted from CDI’s jurisdiction.

Historically, insurers were limited to the traditional fee-for-service model of indemnity health insurance pursuant to which the insured had an essentially unfettered choice of providers for covered treatment. Beginning in 1982, the Insurance Code authorized insurers to enter into alternative rates of payment contracts that, as a practical matter, were necessary to create Preferred Provider Organizations (“PPOs”) products. PPO products offer the insured favorable rates for selecting in-network providers while maintaining the option of seeking health services out-of-network. The Insurance Code was further amended during the early 1980s to permit insurers to offer Exclusive Provider Organization (“EPOs”) products, where the insured is limited to seeking services in-network and has no out-of-network option under the contract.

DMHC is the primary regulator of health care service plans, which offer a wide variety of health care products including full-service managed care, PPO, EPO and Point of Service (“POS”) products. DMHC’s exclusive focus is on the health care plan market and on protecting consumers, providers and market participants within that market. DMHC oversees a market with almost \$47 billion in annual revenues which provides health, dental, vision, psychological and/or other services to over 22 million full-service enrollees and over 64 million enrollees in all product lines.

There are more similarities than differences in the bureaucratic structures and regulatory activities of DMHC and CDI. Both agencies have divisions to deal with consumer services, market conduct, financial surveillance, and licensing and administration, among other things, although there is no question that DMHC’s divisions have a greater health focus than the analogous divisions within CDI. This

study examines the similarities and differences between the two departments with respect to the following consumer protections and regulatory activities:

- Benefit Packages
- The Hotlines and Grievance Resolution
- Independent Medical Review
- Quality of Care and Market Conduct Examinations
- Solvency Regulation
- Taxes

It is apparent that DMHC and CDI have somewhat different strengths. DMHC's comparative strengths are its exclusive focus on health care, the development of a consumer grievance program with specified timelines for dispute resolution, administration of the independent medical review system, its quality of care monitoring, and its consumer health care education programs. CDI's comparative strengths are its financial surveillance programs, its ability to respond to consumer questions and complaints from an insurance perspective, and its national connections to regulators in other states who regulate a national, indeed a global, insurance market.

There seems to be general agreement that consumers and others are often confused about the identity of the appropriate regulator under current law. This problem is most apparent in the large number of calls to CDI which must be referred to DMHC (about 5,500 calls annually). There also seems to be general agreement that certain types of consumer protections should apply equally whether dealing with an HMO regulated by the Department of Managed Health Care or an indemnity or indemnity-PPO regulated by the Department of Insurance.

Finally, there is a general acknowledgment among stakeholders that, in theory, a single regulator would be preferable. Most seem to agree that it is a little awkward to have two regulators, one appointed by the Governor and the other independently elected, with somewhat overlapping jurisdiction over somewhat similar products that compete in many of the same markets. Although a single regulator would be preferable *in theory* (or, alternatively, two regulators both of whom were appointed by and accountable to the same person), there is substantial disagreement about whether that can or should be achieved in California *in practice* given the existing bifurcation of authority between the Department of Managed Health Care and the Department of

Insurance. It is worth remembering that regulatory jurisdiction over health insurance and health plans has been divided for over sixty years in California, first between CDI and the Attorney General, and then between CDI and the Department of Corporations (and now DMHC).

The fact that jurisdiction has been divided from virtually the inception of health care service plans in California may suggest that there is really no pressing need for regulatory consolidation at this moment. Arguably, consolidation may only marginally improve regulatory consistency, but at the possible cost of over-burdening an already rapidly expanding agency, DMHC, that finds itself very much in the public spotlight, and at the possible cost of causing some health insurance products to exit the market. On the other hand, in light of bureaucratic stasis and political reality, substantial organizational and regulatory change in government usually must take place opportunistically, for example because of one or more flash points (such as major scandals in an industry or agency), because political considerations make organizational change possible during a brief period of time, or because of a carefully cultivated consensus for change.

Five broad options for regulatory reform are presented in the final chapter of this report as follows:

- Equalizing Hotline Performance Without Altering CDI's or DMHC's Regulatory Jurisdiction
- Equalizing Other Consumer Protections Without Altering CDI's or DMHC's Regulatory Jurisdiction
- Functional Regulation With Each Agency Having Regulatory Jurisdiction Over Certain Aspects of Health Insurers and Health Care Plans
- DMHC Jurisdiction Over All Health Insurance
- DMHC Jurisdiction Over All EPOs and/or PPOs

Each of these options has advantages and disadvantages, which vary somewhat from stakeholder to stakeholder, and each option has practical and political hurdles which would have to be overcome. Because these options and the discussion of pros and cons cannot be summarized without losing significant content, no attempt is made in this chapter to provide a summary, which would be more misleading than helpful. Readers who desire to skip the comparative analysis of the two departments and their

regulatory jurisdiction and activities should skip ahead to chapter III (although a complete understanding of chapter III is probably not possible without carefully reviewing chapter II).

Chapter II.

Existing Regulatory Structure

A. Brief Overview of Health Insurance Regulation

The history of regulation by California state agencies over health insurance-like products and organizations is a history of divided responsibility. For purposes of this report, a useful starting point is the California Supreme Court's decision in *California Physicians' Service v. Garrison*, 28 Cal.2d 790 (1946), although the history certainly extends beyond 1946 to the early decades of the 20th century. Various officers and councilors of the California Medical Association organized a non-profit corporation called "California Physicians' Service" to make available medical care for those who desired it but, because of financial limitations, found the cost of sickness a burden not easy to bear. The service opened itself for professional membership to all licensed physicians and surgeons in the State. Consumers, who were described as "beneficiary members," individually enrolled pursuant to a contract entered into by the service on behalf of the professional members with a lodge, professional organization, social club, or other group having a means of collecting the monthly dues required to be paid for each person desiring to be included in the corporation's plan for beneficiary membership. Contracts could also be entered into with an employer who agreed to deduct membership fees from payroll. Each beneficiary member was entitled to secure, when needed and for a period not to exceed one year for any one illness or injury, medical and surgical services from the professional members.

A dispute arose between the California Physicians' Service and the Department of Insurance ("CDI") over the question of whether the service was required to secure a license from CDI. The Service filed a declaratory judgment action seeking a determination that it was not engaged in the business of insurance under the Insurance Code.

Foreshadowing some of the same confusion that continues to bedevil attempts to distinguish health insurance from contracts to provide health services, the court held that California Physicians' Service was *not* in the business of insurance and was not subject to CDI's jurisdiction. In part, the rationale for the court's decision was that the Service did not itself assume any of the risk associated with providing medical services for a pre-determined, periodic fee. Instead, the Service was more properly characterized as a *distributor* of risk to the individual professional members who looked solely to the monthly dues of the beneficiary members for compensation.

In addition, the court explained that “[t]he question, more broadly, is whether, looking at the plan of operation as a whole, ‘service’ rather than ‘indemnity’ is its principal object and purpose.” *Id.*, 28 Cal.2d at 809. The court answered the question as follows:

Certainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary, low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably this is “service” of a high order and not “indemnity.”

Id., 28 Cal.2d at 809.

Pursuant to legislation enacted in 1941, the California Physicians’ Service was subject to the very general supervisory jurisdiction of the Attorney General as a charitable organization. The Service ultimately became what we know as Blue Shield of California.

As a result of *Garrison*, the principle was established early on in California law that certain types of health service plans would *not* be regulated by CDI notwithstanding some similarities in the products being offered to products offered by insurers.

For many years after the *Garrison* decision, Blue Shield operated with virtually no regulatory oversight because the Legislature never appropriated funds to fully staff the Attorney General’s office for the purpose of providing the necessary oversight. However, with the growth of the Ross-Loos Medical Group and the Kaiser Foundation Health Plan, concerns mounted about the absence of effective regulatory oversight. The result was the passage in 1965 of the Knox-Mills Act which had the effect of creating a special unit in the Attorney General’s office to administer its provisions. 1965 Cal. Stats., ch. 880.

As a result of the rapid expansion in the late 1960s and early 1970s of so-called “prepaid health plans” (PHPs) and some financial scandals associated with PHPs, the

Legislature stepped up the level of regulatory oversight by enacting the Knox-Keene Health Care Service Plan Act of 1975. 1975 Cal. Stats., ch. 941. The Attorney General at the time no longer wanted to have jurisdiction of health plans, and a dispute arose regarding which agency should have jurisdiction. Some of the affected companies were still strongly opposed to being subject to CDI jurisdiction, and other companies were opposed to being regulated by the Department of Health. The story is told that Assemblyman Knox, who had been the author of all Department of Corporations legislation for several years, came up with the idea of assigning jurisdiction to the Department of Corporations, which was primarily responsible for securities regulation at that time. Absent any significant opposition to that choice, the Department of Corporations became the home for health care service plan regulation.

Regulatory jurisdiction over health care services is *not* limited simply to CDI and the Department of Managed Health Care (“DMHC”), which is the successor to the Department of Corporation’s jurisdiction over health care plans. In addition to these two regulatory entities, various aspects of our health care system are regulated at the state level by the Department of Health Services, the Managed Risk Medical Insurance Board, the Department of Industrial Relations, the Department of Consumer Affairs, the Office of the Attorney General. Federal health care oversight of managed care is similarly split with responsibilities divided between the Department of Health and Human Services, Department of Defense, Department of Transportation, Department of Labor, Social Security Administration, Department of Veterans Affairs and Office of Personnel Management.

It was against this backdrop of divided jurisdiction and responsibility that the Managed Health Care Improvement Task Force issued its 1998 background paper and recommendations regarding regulatory reorganization. *See* “Government Regulation and Oversight of Managed Health Care -- Background Paper,” *Improving Managed Health Care in California*, Volume III, pp. 7-34 (January 1998). An extended quote from that background paper serves as a good introduction to the remainder of this report:

The debate over regulatory organization in 1996 and early 1997 centered on whether responsibility for regulatory oversight of Knox-Keene plans should remain at the Department of Corporations or be shifted to another state organization. Among those alternatives to the status quo that were cited were the Department of Consumer Affairs, the

Insurance Commissioner, or the Health and Welfare Agency.

The authors wish to point out that Task Force recommendations on regulatory organization will be most thoughtful if they include not only *who* should be the regulator, but also *what* segments of the industry they should regulate, and *how*. The three elements are interdependent and cannot be intelligently treated in isolation. Components of “how” are addressed in a number of Task Force papers. Therefore, here we will offer recommendations only about “who.” First, however, some observations about “what” should be regulated.

The health care industry is evolving quickly, with substantial consolidations both vertically and horizontally. The regulatory architecture must be modernized to keep pace. There are substantial advantages to consolidating regulation of different segments of the industry in the same organization, where those segments are emerging as partial substitutes. For example, as health plans shift more financial risk onto medical groups, those groups will begin to act increasingly as substitutes for the plans. Whatever argument compels regulation of health plans should apply to pseudo-plans, such as risk-bearing medical groups, as well.

If the jurisdiction of a regulator should extend beyond traditional prepaid health plans, how far should it go? It could include the following, in order of priority:

(a) Medical groups, for the reason cited above. One approach would be to broaden the issuance of limited Knox-Keene licenses. However, an alternative approach is to hold health plans accountable for the errors of their vendors, including medical groups, and make the plans responsible for policing their suppliers. That is DOC’s approach today; however, it can be strengthened and streamlined

(b) Indemnity health insurance, including PPOs and EPOs, because it is a substitute for prepaid health plans (albeit with a shrinking share of the market).

(c) Individual health professionals’ licensure, which primarily

emphasizes basic competence, not other criteria such as financial solvency.

(d) Health facilities (hospitals, outpatient clinics, or nursing homes).

Collectively this group encompasses the jurisdictions of portions of the Department of Corporations, Consumer Affairs, Health Services, and the Insurance Commissioner.

Id., pp. 31-32.

Although the issue of regulatory consolidation was raised by the Task Force, the legislation creating the Department of Managed Health Care did not attempt any consolidation of regulatory functions. Instead, the Legislature mandated a study and report on the issue. Section 1342.3 of the Health and Safety Code provides as follows:

The director [of DMHC] shall, in conjunction with the Advisory Committee on Managed Health Care, undertake a study to consider the feasibility and benefit of consolidating into the Department of Managed Health Care the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products regulated by the Department of Insurance. The results of the study along with the recommendations of the director shall be incorporated into a report to the Governor and the Legislature no later than December 31, 2001.

B. Regulatory Jurisdiction Over HMOs and PPOs in Other States

In considering how to structure regulatory jurisdiction over health insurance and health care service plans in California, it is instructive to consider how other states have dealt with the same problem. It appears that around 40 states have a unitary regulatory structure in which a single regulator, the department of insurance, is primarily responsible for regulating companies that provide one form or another of health coverage, including indemnity health insurance, health care plans, preferred provider organizations (“PPOs”), exclusive provider organizations (“EPOs”), and point

of service plans (“POSs”). There is thus a clear preference for (a) a single regulator of health insurance and health insurance-like products and (b) that the single regulator be the department of insurance. The department of insurance is the primary regulator of indemnity health insurance in all states except one, and the exceptional state, Hawaii, divides jurisdiction over all health coverage companies between the department of insurance and the department of labor & industrial relations.

States in which regulatory jurisdiction over health care plans, PPOs, EPOs and POSs is divided include California, Delaware, Hawaii, Michigan, Minnesota, New Jersey, New York and Oklahoma. The Regulatory Implementation and Structure Subcommittee heard from regulators in North Carolina, New Jersey and Oklahoma regarding their state’s regulatory structures and practices.

In North Carolina, the Department of Insurance is the sole regulator of indemnity health insurers and HMOs. HMOs are separately licensed by the Department of Insurance, and the HMO license does *not* convey authority to sell other types of health plans or health insurance (which may be offered by insurers which are approved to write life, accident and health insurance). Preferred providers, defined by statute as “a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer” (N.C. Gen. Stats. § 58-50-56(2)), are not directly regulated by the Department of Insurance, although the Department regulates insurers that offer a PPO benefit plan. North Carolina’s legislature and Department of Insurance have been grappling with the same set of issues that have been considered in California in recent years, and both statutes and regulations have been adopted dealing with minimum benefits, mandated benefits, provider network requirements, provider protections, utilization review, appeals and grievances, quality assurance programs, marketing and advertising, information and disclosure requirements, premium rates and financial solvency.

In New Jersey, oversight of health care plans and insurance is jointly administered by the Department of Health and Senior Services, which is primarily responsible for HMOs, and the Department of Banking and Insurance, which is primarily responsible for all other health insurance products. The relevant statutes specify which agency is the lead agency with respect to particular regulatory responsibilities, and the two departments regularly consult with each other to coordinate their activities. As a general matter, regulatory activities that require expertise in matters of medicine and health care are assigned to the Department of

Health and Senior Services while matters that require expertise in financial and insurance practices are assigned to the Department of Banking and Insurance. In short, New Jersey has adopted a form of “functional regulation” where the expertise of each agency is brought to bear in regulating health insurance and health care plans.

Finally, in Oklahoma, the Department of Health is the primary regulator of HMOs, although the Department of Insurance has the right to express recommendations to the Department of Health about fiscal responsibility and fiduciary integrity. About 12 different types of filings with the Department of Health are now required to be forwarded to the Department of Insurance so that it may exercise its right to express recommendations. Other types of health insurance products, including indemnity health insurance and PPOs, are regulated by the Department of Insurance. Under current Oklahoma law, PPOs that contract directly with employers or individuals are not regulated.

We turn now to a general description of the regulatory jurisdiction of the Department of Insurance and the Department of Managed Health Care. After that general overview, more specific comparisons are drawn between the two departments with respect to the following consumer protections and regulatory programs:

- Benefit Packages
- The Hotlines and Grievance Resolution
- Independent Medical Review
- Quality of Care and Market Conduct Examinations
- Solvency Regulation
- Taxes

C. Regulatory Jurisdiction of the Department of Insurance

The purpose of this study is to develop options pertaining to the feasibility and desirability of transferring jurisdiction over one or more types of health insurance from the Department of Insurance to the Department of Managed Health Care. In light of this purpose, it is appropriate to begin with a review of the Department of Insurance’s jurisdiction over health insurance.

1. General Background

The California Department of Insurance (“CDI”) is an independent agency within the Executive Branch of government that regulates the business of insurance. CDI is led by the Insurance Commissioner, who, by virtue of Proposition 103, is a statewide elected official.

By any measure, CDI is a large organization with a wide variety of responsibilities and powers. CDI regulates an \$86.4 billion insurance industry in California, comprised of 26 different lines of insurance offered by some 1,400 qualified insurers, some of which operate only domestically, but many of which operate nationally. The Department collects \$1.3 billion annually in premium and surplus line taxes that are deposited into the State’s general fund. The Department licenses 257,000 “resident” agents and brokers and over 77,000 “non-resident” agents and brokers. Every month, it receives over 4,000 applications for new agents/brokers and over 8,500 renewal applications from agents/brokers. CDI handles over 50,000 phone calls every month from agents, brokers and companies, with staff responding to 15,000 of these calls and an Interactive Voice Response (“IVR”) system handling the remainder. CDI’s consumer hotline, discussed in greater detail below, responds to over 35,000 calls each month.

CDI has 1,374 authorized positions for fiscal year 2000-2001. These employees are located in 16 offices throughout California. The 3 largest offices are located in Sacramento (401 employees), San Francisco (203 employees) and Los Angeles (416 employees).

The Department’s budget for fiscal year 2001-2001 is \$159.5 million (\$126 million of which is for state operations and \$33.5 million of which is for local assistance). Only \$1.1 million comes from the State’s general fund. The remainder of the funds comes from the State’s insurance fund, which includes license fees, penalties, and fines, exam fees, and assessments required by Proposition 103 and other insurance services such as investigations and enforcement actions. Thus, CDI’s regulatory structure is almost entirely financed by assessments on insurers. CDI’s assessments are not directly dependent upon the number of policy-holders or enrollees which an insurer has (although larger companies generally must pay more to CDI because the regulatory burden which those larger companies impose upon CDI is greater than the regulatory burden imposed upon by CDI by smaller companies).

CDI's organizational chart reflects the Department's functional operations. The executive staff level includes the following divisions:

- Consumer Services & Market Conduct.
- Financial Surveillance.
- Rate Regulation.
- Criminal Investigations.
- Administration and Licensing Services.
- Legal/Chief Counsel.
- E-Government & Technology Solutions.
- Strategic Planning, Policy & Research.
- Internal Audits / Information Security Office.
- Conservation & Liquidation Office.
- Office of Community & Constituent Affairs.
- Special Projects / Special Assistant to Commissioner.
- Legislative Office.
- Media Relations.

CDI's stated missions, according to its "Strategic Plan 2001," are to protect consumers; foster a vibrant, stable, marketplace; maintain an open, equitable regulatory process; and, fairly and impartially enforce the law. Its goals are to build a strong, collaborative organization that works toward a common purpose; to reach out to constituencies to restore public trust and a positive image for the Department; to assure consumers are treated fairly by the industry; to reduce insurance-related crimes; and, to minimize financial insolvencies of insurers. CDI's values are to be honest, open and fair; knowledgeable, accurate and consistent; accessible, responsive, and accountable; efficient and effective; and, to provide innovative leadership.

2. CDI's Health Insurance Jurisdiction

Until just this year, CDI has regulated what is commonly known as health insurance pursuant to its statutory authority to regulate "disability insurance," one of the 26 lines of insurance encompassed by California's Insurance Code. *See generally* Ins. Code § 100 (listing primary lines of insurance). "Disability insurance" is defined to "include[] insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from

sickness.” Ins. Code § 106(a). Pursuant to legislation enacted this year, which will become effective on January 1, 2002, “health insurance” is now defined for purposes of the Insurance Code as “an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits,” excluding a list of enumerated types of policies (e.g., accidental death; disability insurance which pays on a fixed benefit, cash payment only basis; credit disability insurance; disability coverage supplemental to liability insurance; disability income insurance; workers’ compensation; and long-term care).

Section 740 of the Insurance Code makes CDI the default regulator for health insurance in California. Subdivision (a) of Section 740 provides as follows:

Notwithstanding any other provision of law, and except as provided herein, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the department unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government.

Subdivision (g) of Section 740 expressly excludes Knox-Keene health care service plans from CDI’s jurisdiction as follows: “A health care service plan, as defined in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be subject to this section.” Pursuant to Section 1346.5 of the Health and Safety Code, if DMHC “determines that an entity purporting to be a health care service plan exempt from the provisions of Section 740 of the Insurance Code is not a health care service plan, the director shall inform the Department of Insurance of that finding.”

CDI does not keep records of the number of licensed insurers which actually offer different types of disability insurance, and it is therefore somewhat difficult to learn from CDI the number of health insurers actually writing coverage in California and how substantial the market for health insurance is. However, CDI has licensed almost 1,000 companies, including life insurers, disability insurers, property & casualty insurers, and fraternal societies, to write disability insurance, and CDI reports that there

are hundreds of policies which provide for hospital, medical and surgical coverage.

3. Pure Indemnity Health Insurance -- Fee-for-Service

The traditional fee-for-service model of indemnity health insurance, where the insured has an unfettered choice of providers, is provided for by Section 10176 of the Insurance Code. Section 10176 provides in pertinent part as follows:

In disability insurance, the policy may provide for payment of medical, surgical, chiropractic, physical therapy, speech pathology, audiology, acupuncture, professional mental health, dental, hospital, or optometric expenses upon a reimbursement basis, or for the exclusion of any of those services, and provision may be made therein for payment of all or a portion of the amount of charge for these services without requiring that the insured first pay the expenses. No such policy shall prohibit the insured from selecting any psychologist or other person who is the holder of a certificate or license under Section 1000 [chiropractors], 1634 [dentistry], 2050 [physicians and surgeons], 2472 [podiatrists], 2553 [dispensing opticians], 2630 [physical therapists], 2948 [psychologists], 3055 [optometry], or 4938 [acupuncturists] of the Business and Professions Code, to perform the particular services covered under the terms of the policy, the certificate holder or licensee being expressly authorized by law to perform those services.

Section 10176 makes it clear that the policy may not “prohibit the insured from selecting” a licensed provider of his or her choice. Because the insured retains the power of choice over providers in an indemnity health insurance system, and providers are separately licensed, CDI’s regulatory responsibilities over indemnity health insurance have historically been limited to traditional insurance matters such as policy approval, financial solvency and claims handling. With an indemnity health insurance product, there is generally no need for CDI to involve itself in quality of care issues since (1) all providers are separately licensed and regulated, and (2) consumers may choose their own providers, thereby creating significant market pressure upon providers to offer acceptable levels of care.

The policy approval process is set forth in Sections 10290 through 10293 of the Insurance Code. As a practical matter, these statutes ensure that a disability policy is

not issued or delivered to any person in this State until the policy and rates are filed *and* approved by CDI.¹ The Insurance Code does not provide for any generally applicable minimum benefit levels or minimum coverage requirements for indemnity health insurance, leaving such matters to be worked out by the marketplace. Certain benefits have been statutorily mandated (a topic discussed below), and CDI ensures during its policy approval process that these benefits are actually offered. There are also certain uniform provisions that must appear in each disability policy dealing with such topics as integration clauses, incontestable clauses, grace periods, reinstatements, notice of claim provisions, claim forms, proofs of loss, time of payment of claim, payment of claims, physical examinations, limitations of actions on the policy, and change of beneficiaries. Ins. Code §§ 10350-10354.

With a pure indemnity health insurance policy, the only disputes likely to arise between the insured and insurer relate to coverage issues and claims handling. The insurance company does not itself make medical judgments regarding the medical necessity of treatment options (except in the course of making certain coverage decisions).

4. Preferred Provider Organizations

The Insurance Code was amended in 1982 to authorize health insurance policies that provided lower copayments by insureds if the insured selected an institutional provider which had contracted for alternative rates of payment with the insurer. This legislation expressly provided that the insurer could not itself furnish or directly provide medical services, thereby distinguishing between the functions of a health plan (regulated by DMHC) and a health insurer (regulated by CDI).

¹ Technically, Section 10290 of the Insurance Code requires only that the policy and rates be filed for thirty days before they may be used. However, Section 10291 provides that “[i]f the commissioner notifies the insurer, in writing, that the filed form does not comply with the requirements of law, specifying the reasons for his opinion, it is unlawful thereafter for any such insurer to issue any policy in such form.” CDI attempts to review policies within the 30-day time-frame set forth in Section 10290, but even when CDI misses that 30-day deadline, the power to reject a policy is retained in Section 10291. As a practical matter, most insurers will not offer a policy until it has been actually approved by CDI in order to avoid the confusion and liability of offering a policy that is subsequently disapproved.

Subdivision (b) of Section 10133 of the Insurance Code contains the critical language authorizing insurers to contract with what are commonly known as Preferred Providers Organizations (“PPOs”):

Nothing in this section shall be construed to authorize an insurer to furnish or directly provide services of hospitals, or psychiatric health facilities, as defined in Section 1250.2 of the Health and Safety Code, or physicians and surgeons, or psychologists or in any manner to direct, participate in, or control the selection of the hospital or health facility or physician and surgeon or psychologist from whom the insured secures services or exercise medical or dental or psychological professional judgment, except that an insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of these alternative rates to insureds who select those providers.

The last clause of this statutory language permits an insurer to negotiate more favorable rates with one or more institutional providers and to offer the benefit of those lower rates to insureds who select those providers. The alternative rates are essentially discounted fee-for-service contracts since any attempt to transfer risk through capitation or risk-adjusted reimbursement would trigger DMHC’s regulatory jurisdiction. The mechanism for passing on the lower rates to insureds is established by Section 10133.2, which provides that “the amount of patient copayment shall be calculated exclusively from the negotiated alternative rate for the service rendered.”

Because Section 10133(b) protects the right of an insured to seek services from a provider of choice, PPOs share to a large extent one of the important characteristics of indemnity health insurance: patient choice. However, the insured’s choice is not entirely unfettered since the choice of provider affects the copayment and thereby introduces into the insured’s decision-making process an economic consideration that is absent in a pure indemnity policy. Nevertheless, the active decision-maker in this model is the insured rather than the insurer or provider. Thus, so long as the copayment differential is not too great and the network of preferred providers is sufficiently large (in other words, so long as the patient has a *genuine* choice), there is little reason for CDI to involve itself in regulating quality of care issues. As noted above, the copayment differential must reflect the alternative rate actually negotiated, so an insurer cannot artificially drive patients to stay within the network of preferred

providers. As for the scope of the provider network, Section 10180(a) of the Insurance Code requires insurers offering PPO products to “give reasonable consideration to timely written proposals for contracting by licensed or certified professional providers” where the proposal offers a type of services not already covered within the network or offers services in different geographic areas. Some PPOs have reported utilization rates of in-network providers in the 70-80% range. These numbers reflect both the copayment differential and the large size of many institutional or professional providers which contract at alternative rates with insurers.

As with indemnity insurance policies, the main disputes that arise between the insured and an insurer offering a PPO product relate to coverage disputes and claims handling.

5. Exclusive Provider Organizations

Subdivision (c) of Section 10133 permits an insurer, by agreement with group policyholders, to “limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with the insurer.” Unlike the PPO product, where the patient still may choose out-of-network services and receive reimbursement for those services (albeit with a higher copayment), the Exclusive Provider Organization (“EPO”) product authorized by subdivision (c) does not reimburse out-of-network services. Thus, patient choice of providers is absent in an EPO product, and there is a correspondingly greater concern with the quality of care offered within the network.

Subdivision (d) of Section 10133 recognizes the legitimate concern with quality of care in EPOs, and it expressly requires that contracts between insurers and providers pursuant to subdivision (c) contain provisions focusing on quality of care. Subdivision (d) provides in full as follows:

Pursuant to subdivision (c), when alternate rates of payment to providers are applicable to contracts with group policyholders, the contracts shall include programs for the continuous review of the quality of care, performance of medical or psychological personnel included in the plan, utilization of services and facilities, and costs, by professionally recognized unrelated third parties utilizing in the case of professional providers similarly licensed providers for each medical, psychological,

or dental service covered under the plan and utilizing in the case of institutional providers appropriate professional providers. All provisions of the laws of the state relating to immunity from liability and discovery privileges for medical, psychological, and dental peer review shall apply to the licensed providers performing the foregoing activities.

Section 10133.5 also required CDI to promulgate regulations application to EPOs “to assure accessibility of provider services to individuals comprising the insured or contracted group.” Specifically, the regulations must ensure:

1. Adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.
2. Adequacy of number of professional providers, and license classifications of such providers, in relationship to the projected demands for services covered under the group policy or plan.
3. The policy or contract is not inconsistent with standards of good health care.
4. All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.

Ins. Code § 10133.5.

In addition, in recognition of the fact that EPOs share more characteristics with health care plans than with pure indemnity health insurance, Section 10133.5 provides that “[i]n designing the regulations the commissioner shall consider the regulations in Title 10, of the California Administrative Code, commencing with Section 1300.67.2 which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of

indemnification.”²

CDI promulgated the required regulations in 1984. 10 Cal. Admin. Code § 2240 through 2240.4. Among other things, the regulations provide that facilities must be located within reasonable proximity to work places or principal residences of the insureds, basic health care services must be available at least 40 hours per week, emergency health care services must be available at all times, the ratios of covered persons to health care staff must be such that services will be accessible without delays detrimental to the health of insureds, specialists are available through staffing, contracting or referral, and there must be a documented system for monitoring and evaluating accessibility of care, including monitoring of waiting time for appointments.

10 Cal. Admin. Code § 2240.1(a). The regulations specifically require as minimums at least one full-time physician for each 1,200 covered persons and one full-time primary care physician for each 2,000 covered persons. 10 Cal. Admin. Code § 2240.1(b). The regulations also provide that “[i]n determining whether an insurer’s arrangements for exclusive provider services comply with the foregoing requirements, the Commissioner shall consider to the extent he deems necessary, the practices of comparable health care service plans licensed under the Knox-Keene Law, Health and Safety Code Section 1340, et seq.” 10 Cal. Admin. Code § 2240.1(c).

The regulations promulgated by CDI with respect to EPOs are essentially the same as DMHC’s regulations dealing with accessibility of services. DMHC’s regulations require that facilities be in reasonable proximity to businesses or residences, hours of operation and provision for after-hour services must be reasonable, emergency health care services must be available at all times, the ratios of enrollees to staff must be sufficient so that services will be available without delays detrimental to the health of the enrollees, there must be one full-time physician for each 1,200 enrollees, and one full-time primary care physician for each 2,000 enrollees, specialists must be available through staffing, contracting or referral, and the plan shall have a

² The reference to “Title 10” in Section 10133.5 is incorrect and should be changed. The Department of Managed Care’s regulations have been moved to Title 28. Although it appears that the cross-reference to the title is incorrect, the reference to “Section 1300.67.2” appears to be accurate.

system for monitoring and evaluating accessibility of care and for addressing problems that develop. 28 Cal. Admin. Code § 1300.67.2(a)-(f).

6. CDI's Focus on Health

Because CDI's regulatory jurisdiction encompasses so much more than health insurance, because the Insurance Code statutes generally do not refer to health insurance and instead refer to "disability insurance," and because CDI's organizational structure has not included a dedicated health insurance unit or division, there is a perception shared by many that CDI has neglected or been indifferent to the regulation of health insurance and the needs of consumers of health insurance. There is some justification for these perceptions. For example, someone visiting CDI's web at www.insurance.ca.gov would be hard pressed to find out information about health insurers regulated by the Department. On one of CDI's pages, a user is supposed to be able to produce a list of insurance companies licensed in California to sell specific lines of insurance. Somewhat remarkably, this page indicates that "you cannot query this page for a list of health insurance carriers licensed by the California Department of Insurance." Users are directed via a link to access DMHC's site for a list of health maintenance organizations.

Although there is some truth to perceptions that health issues are subordinated within CDI's organizational structure, the criticisms are overstated. The fact that CDI is *not* organized by line of insurance is one of CDI's important strengths because this ensures that uniform standards of financial solvency, claims handling, enforcement and criminal investigations, and consumer responsiveness are applied to *all* lines of insurance equally. Moreover, most of the insurers which sell one or more products within the disability line of insurance also sell products that are within other lines of insurance (e.g., a company which markets health insurance to an employer for the benefit of employees may also offer life insurance and workmen's compensation products to the employer). CDI's organizational structure keeps the focus on the overall stability of the insurance marketplace and of individual insurers, irrespective of the lines of insurance being offered.

In part in response to the attention on CDI fostered by this regulatory study, CDI has taken several steps this year to focus on health insurance. First, CDI created a special health insurance task force to work on the regulatory study. As explained in CDI's Strategic Plan 2001, the two departments "are establishing a strong and effective

working relationship to bring our experience, knowledge and perspectives to the regulatory framework study effort with the goal to achieve the most effective system for consumers and the industry.” Strategic Plan 2001, p. 6. Second, CDI indicates that it plans to review and evaluate the jurisdictional regulatory lines between the Department of Managed Health Care and the Department of Insurance to identify opportunities for efficiency and combined collaborative approaches to the Health Insurance marketplace. Strategic Plan 2001, p. 11. Third, and of greatest lasting significance, CDI has created a new exempt position at the executive level to advise the Insurance Commissioner on health care issues and to coordinate CDI’s health insurance regulatory activities. The new position is the “Commissioner’s Disability Insurance and Health Care Issues Advisor.” The advisor will have the following responsibilities:

The California Insurance Commissioner has regulatory authority and responsibility for the disability insurance marketplace, and is involved with broad policy decisions on a host of health care issues that require specialized experience and attention. The incumbent will represent the Commissioner and Department’s positions on policy matters, legislative bill analysis and committee testimony, work cooperatively with the Department’s internal senior management and disability insurance and health care issues task force leaders, the National Association of Insurance Commissioners, and a variety of other federal and state government oversight and regulatory agencies.

In light of these concrete steps towards a more sustained and systematic focus on health care issues, greater collaboration and coordination with DMHC, and a commitment to improving the regulation of health insurance for the benefit of consumers and the industry, concerns about CDI’s organizational engagement on health-related issues should be somewhat ameliorated.

D . Regulatory Jurisdiction of the Department of Managed Health Care

1. General Background

The Department of Managed Health Care (“DMHC”) was established by AB 78 (Gallegos) in 1999. 1999 Cal. Stats., ch. 525. Prior to this legislation, Knox-Keene health care plans were regulated by a division within the Department of Corporations. AB 78 transferred the regulatory responsibilities from the Department of Corporations

to a newly-established Department of Managed Health Care.

DMHC protects the public through administration and enforcement of state laws regulating health care plans. The administration of these laws involves a variety of activities including licensing, examination, and responding to public inquiries and complaints. DMHC's health plan program assures the accessibility and availability of medically necessary health care delivered to the public with appropriate quality-of-care oversight and through financially sound managed care plans. The program licenses health care service plans, conducts routine financial and medical surveys, and operates a consumer services toll-free hotline. DMHC is advised by three boards comprised of a broad cross-section of health care leaders including providers, purchasers and consumers: the Advisory Committee on Managed Care, the Clinical Advisory Panel, and the Financial Solvency Standards Board.

DMHC regulates an industry with almost \$47 billion in annual revenues which provides health, dental, vision, psychological and/or other services to over 22 million full-service enrollees and over 64 million enrollees in all product lines. There are over 120 health plans operating in California. In addition to specific fees for certain filings, all plans are required to pay a general assessment to finance DMHC's regulatory activities depending upon the number of plan enrollees. Health & Safety Code § 1356.

DMHC's organizational structure, like CDI's organizational structure, reflects its functional operations. The executive staff level includes the following divisions:

- HMO Help Center.
- Financial Solvency Standards Board.
- Medical Advisor to the Director's Office.
- Office of Health Plan Oversight.
- Office of Enforcement.
- Office of Administrative Services.
- Office of Legal Services.
- Office of Technology and Innovation
- Office of the Patient Advocate.
- Plan & Provider Relations.
- External Affairs / Legislative Program.

2. DMHC's General Jurisdiction Over Health Care Service Plans

In pertinent part, Section 1345(f) of the Health & Safety Code defines a health care service plan as “[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.” Health & Safety Code § 1345(f)(1). It is “unlawful for any person to engage in business as a plan . . . unless such person has first secured from the director a license” Health & Safety Code § 1349.

The broad definition of health care service plans set forth above might appear to encompass all disability insurance products that are regulated by CDI since such products pay for or reimburse the cost of health care services. However, subdivision (e)(1) of Section 1343 of the Health and Safety Code carves out insurance products from DMHC’s jurisdiction as follows: “This chapter shall not apply to . . . [a] person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer’s plan and to the insurer.” Thus, insurance companies offering health insurance must avoid “directly providing the health care service” in order to avoid being subject to the dual jurisdiction of both DMHC and CDI. *See also* Health & Safety Code § 1349 (“A person licensed pursuant to this chapter need not be licensed pursuant to the Insurance Code to operate a health care service plan or specialized health care service plan unless the plan is operated by an insurer, in which case the insurer shall also be licensed by the Insurance Commissioner.”). The distinction in these statutes between providing indemnity and providing services has a long history in California law tracing back to the 1946 decision in *California Physicians’ Service v. Garrison*, 28 Cal.2d 790 (1946), which was discussed above.

All of the entities regulated by DMHC offer, in one form or another, traditional health care service plan products where the plan agrees to provide medical services to enrollees through a health maintenance organization (“HMO”). An HMO is simply an entity that provides health care through participating providers in a geographic area and accepts the responsibility for providing or otherwise assuring the delivery of an agreed-upon set of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of persons. In general, providers or provider groups are reimbursed for services either through capitation -- a predetermined, fixed, periodic

payment made by, or on behalf of, each person of family enrolled regardless of the amount of care actually received -- or through some variation on the indemnity arrangement. An enrollees' costs will be covered only if they stay within the HMO panel of providers and adhere to the plan's referral and authorization rules.

In an HMO, the plan has the power to decide that certain medical services for an individual enrollee will be delayed, denied or modified because the services fall outside the scope of the contract with the enrollee. The most common reasons for a delay, denial or modification are the plan's determination that particular services are either not medically necessary or are experimental or investigational. The fact that the plan has power to decide not to offer services is one of the features that distinguishes HMOs from indemnity health insurance or PPOs. An insurer offering indemnity health insurance or a PPO product decides only whether to reimburse for particular services, leaving the decision of whether services will be provided and, if so, by whom, to the patient and his or her provider. By contrast, a health care service plan may itself be involved in the decision of whether certain medical services will be provided by a plan provider.

Because a health care service plan has greater involvement in deciding whether medical services will be provided to an enrollee, there is correspondingly greater concern about the quality of care provided to enrollees by health care service plans and about grievance and dispute resolution processes when medical services are denied over the patient's objections. In order to facilitate the exercise of its jurisdiction, DMHC generally requires that plans maintain books and records within California. Health & Safety Code § 1381(b) ("To the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state.").

3. Preferred Provider Organizations

A few entities regulated by DMHC offer stand-alone PPO products. Like PPO products offered by CDI-regulated entities, these products provide enrollees with lower copayments for in-network services than for out-of-network services. The lower copayments reflect the discounted alternative rates which plans are able to negotiate with professional providers. Health & Safety Code § 1373.18. Plans are also required to "give reasonable consideration to timely written proposals for affiliation by licensed or certified professional providers." Health & Safety Code § 1373.9.

In theory, a plan offering a PPO could enter into a financial arrangement with professional providers that transfers some of the economic risk from the plan to the providers (e.g., provisions similar to capitation or a contract that provides for risk-adjusted reimbursement depending upon utilization). As noted above, an insurer regulated by CDI would *not* be able to enter into such an arrangement without triggering DMHC jurisdiction, but a plan already regulated by DMHC would not seem to be legally barred from such an arrangement. As a practical business matter, however, it does not appear that these type of financial arrangements make sense in the PPO context. Instead, it appears that plans offering PPO products enter into discounted fee-for-service contracts of precisely the same sort as are entered into by insurers offering PPO products under the Insurance Code.

As a result, PPO products offered by health care service plans have the same essential characteristic as PPO products offered by insurers: the choice of providers is ultimately made by the patient. So long as there is a genuine choice, the copayment differential is not too great, and the network of PPO providers is sufficiently large, there is less reason than with an HMO for DMHC to be concerned about quality of care issues in the PPO context.

4. Point of Service Products

One of the most recent developments in the market is the creation of Point of Service (“POS”) products that essentially merge the services of an HMO with the out-of-network options of a PPO. A POS contract is defined as “any plan contract offered by a health care service plan whereby the health care service plan assumes financial risk for both ‘in-network coverage or services’ and ‘out-of-network coverage or services.’” Health & Safety Code § 1374.60(a). As with PPOs, when an enrollee selects out-of-network services, the enrollee must make a higher copayment, thereby sharing some of the costs of the out-of-network service.

Unlike PPO arrangements described above where the provider is reimbursed essentially on a fee-for-service basis, a POS contract with a provider “may include risk-sharing arrangements for out-of-network services” which may include a “bonus or incentive to the medical provider to attempt to reduce the utilization of out-of-network services.” Health & Safety Code § 1374.66(e) & (e)(4). In order to limit the potential impact of these risk-sharing arrangements, most plans must limit their POS contracts “so that no more than 50 percent of the plan’s total premium revenue in any fiscal

quarter is earned from point-of-service plan contracts,” and plans “shall not expend in any fiscal-year quarter more than 20 percent of its total health care expenditures for all its enrollees for out-of-network services for point-of-service enrollees.” Health & Safety Code § 1376.67(a) & (b).

E. Benefit Package

1. Requirements for Insurers Under the Insurance Code

As noted above, all disability policies must be approved by CDI. Ins. Code § 10290. The Insurance Code does not contain any requirement that disability policies include basic health care services. Thus, with certain statutory requirements mentioned below, the medical services which will be reimbursed under a disability policy are determined by the policy and the agreement between the insurer and insureds. As noted above, there are also certain uniform provisions that must appear in each disability policy dealing with such topics as integration clauses, incontestable clauses, grace periods, reinstatements, notice of claim provisions, claim forms, proofs of loss, time of payment of claim, payment of claims, physical examinations, limitations of actions on the policy, and change of beneficiaries. Ins. Code §§ 10350-10354. Finally, CDI has power to withdraw approval of a disability policy upon a finding “that the benefits provided under the policy are unreasonable in relation to the premium charged.” Ins. Code § 10293(a).

There are a series of statutes requiring that group disability policies which cover hospital, medical or surgical expenses must also cover or offer to cover certain specified benefits, including the following:

- Offer for treatment of alcoholism (Ins. Code § 10123.6)
- Offer for preventive care of children ages 17 and 18 (Ins. Code § 10123.55)
- Comprehensive preventive care of children age 16 & under (Ins. Code § 10123.5)
- Specified equipment, supplies and services used in the treatment of diabetes (Ins. Code § 10176.61)
- Prenatal testing pursuant to Expanded Alpha Feto Protein program (Ins. Code § 10123.184)
- Screening for, diagnosis of, and treatment for, breast cancer (Ins. Code § 10123.8)

Prosthetic devices to restore speaking ability incident to laryngectomy (Ins. Code § 10123.82)
Standards for maternity coverage (Ins. Code § 10123.87)
Reconstructive surgery (Ins. Code § 10123.88)
Standards for mastectomies and lymph node dissections (Ins. Code § 10123.86)
Screening and diagnosis of prostate cancer (Ins. Code § 10123.83)
Mammography for screening or diagnostic purposes (Ins. Code § 10123.81)
Generally medically accepted cancer screening tests (Ins. Code § 10123.20)
Diagnosis, treatment and management of osteoporosis (Ins. Code § 10123.185)
OB-GYN services and direct access to obstetrician and gynecologist (Ins. Code §§ 10123.83 & 10123.84)
Offer for prenatal diagnosis of genetic disorders (Ins. Code § 10123.9)
Anesthesia for dental procedures (Ins. Code § 10119.9)
Offer for orthotics (Ins. Code § 10123.7)
Offer for special footwear for persons suffering from foot disfigurement (Ins. Code § 10123.141)
Offer for treatment of infertility (Ins. Code § 10119.6)

As part of its policy review process, CDI ensures that these statutorily-mandated coverages are included or offered in each disability policy.

2. Requirements for Plans Under Knox-Keene

Unlike insurers, which are not required to cover basic health care services, plans regulated by DMHC are generally required to provide a minimum level of services. Section 1367(i) of the Health & Safety Code provides that “[e]ach health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345” subject to exceptions which may be granted by the Director of DMHC. The basic health care services set forth in Section 1345(b) are as follows:

- (1) Physician services, including consultation and referral.
- (2) Hospital inpatient services and ambulatory care services.
- (3) Diagnostic laboratory and diagnostic and therapeutic radiological services.
- (4) Home health services.
- (5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage, and including ambulance and ambulance transport services provided through the A911@ emergency response system.

(7) Hospice care.

Section 1367(i) provides that the Director “shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter.”

In addition to the basic health care services required by Section 1367, the Legislature has enacted a number of mandated benefits, including the following:

Offer for treatment of alcoholism (Health & Safety Code § 1367.2)

Offer for preventive care of children ages 17 and 18 (Health & Safety Code § 1367.3)

Comprehensive preventive care of children age 16 & under (Health & Safety Code § 1367.35)

Specified equipment, supplies and services used in the treatment of diabetes (Health & Safety Code § 1367.51)

Prenatal testing pursuant to Expanded Alpha Feto Protein program (Health & Safety Code § 1367.54)

Screening for, diagnosis of, and treatment for, breast cancer (Health & Safety Code § 1367.6)

Prosthetic devices to restore speaking ability incident to laryngectomy (Health & Safety Code § 1367.61)

Standards for maternity coverage (Health & Safety Code § 1367.62)

Reconstructive surgery (Health & Safety Code § 1367.63)

Standards for mastectomies and lymph node dissections (Health & Safety Code § 1367.635)

Screening and diagnosis of prostate cancer (Health & Safety Code § 1367.64)

Mammography for screening or diagnostic purposes (Health & Safety Code § 1367.65)

Generally medically accepted cancer screening tests (Health & Safety Code § 1367.665)

Diagnosis, treatment and management of osteoporosis (Health & Safety Code § 1367.67)

OB-GYN services and direct access to obstetrician and gynecologist (Health & Safety Code §§ 1367.69 & 1367.695)

Offer for prenatal diagnosis of genetic disorders (Health & Safety Code § 1367.7)

Anesthesia for dental procedures (Health & Safety Code § 1367.71)

Offer for orthotics (Health & Safety Code § 1367.18)

Offer for special footwear for persons suffering from foot disfigurement (Health & Safety Code § 1367.19)

Offer for treatment of infertility (Health & Safety Code § 1374.55)

These are the same set of benefits that insurers are required to cover or offer to cover pursuant to the Insurance Code.

F. The Hotlines and Grievance Resolution

Both departments operate hotlines to address questions and problems arising within their regulatory jurisdictions. There are some differences in how the hotlines operate and in the nature of the health-related problems and disputes handled by the hotlines.

1. DMHC's HMO Help Center

The DMHC hotline is operated in Sacramento by the "HMO Help Center." The main hotline number is 888-HMO-2219. The HMO Help Center's hotline is open 24 hours a day, 7 days a week and is available to those speaking dozens of languages. The hotline is designed to assist consumers and others in resolving complaints, to ensure that medical decisions take priority, and that patients are always put first. Based on the number of calls received during the first six months of 2001, it is likely the hotline will handle over 200,000 calls this year.

The HMO Help Center is supervised by an Assistant Deputy Director of DMHC, a CEA III position, who is part of the executive leadership team at DMHC. The HMO Help Center has four separate divisions to handle different subject matters, the Division of Business Process and Analysis, the Division of Complaint and Independent Medical Review, the Division of Legal Case Review, and the Division of Preventative Health Intervention. The Division of Complaint and Independent Medical Review, with approximately 35 consumer representatives, has the largest

number of staff providing direct assistance to consumers and others on the hotline. These representatives are assisted, when appropriate, by a medical consultant and several nurse evaluators. The Help Center contracts with a private vendor which operates an external call center to handle overflow and off-hours calls.

A caller to the DMHC hotline must first navigate through an automated menu of the following options on its Interactive Voice Response (“IVR”) system:

- 1 For Spanish
- 2 For telephone numbers of medical and dental HMOs and health plans
- 3 To speak with an agent regarding a problem with health plan
- 4 If you have an urgent care issue that requires immediate attention
- 5 To seek an Independent Medical Review
- 6 If you have a problem with denial of benefits
- 7 To determine status of a previous complaint or report additional information

About 44% of all calls to the hotline are handled by the automated IVR system without the need for any additional consultation. Many consumers hang up after being given DMHC’s website address and probably seek information from the web. A large number of calls are for the purpose of getting telephone numbers of HMOs and health plans, and the IVR system handles these calls as well. Finally, each of the other options above gives the consumer a certain amount of important information before connecting the consumer with an operator (e.g., if you have a grievance, you must first contact your plan before calling DMHC), and a large number of calls wash out at these points.

Of the remaining calls, about 24% are handled by DMHC operators, and 23% are handled by the external call center. The hotline has a separate line for Spanish and has contracted with Language Line Services Inc. for translation services for other languages.

A relatively small percentage of calls to DMHC are referred to other agencies, including referrals to CDI, the Department of Health Services, the United States Department of Labor, HCFA / Medicare, HICAP, MRMIB, the Aids Foundations, and the Cancer Institute, among others. The highest percentage of referred calls (often exceeding 50% per month) are referred back to a plan’s grievance process for

completion of the 30-day HMO grievance process. The next highest percentage of calls are simply coded as “general information.” Only a small percentage of calls each month deal with more substantive issues such as claim or billing problems, disenrollment or termination of coverage, premium or rate increases, medical necessity or independent medical review inquires.

DMHC’s hotline handles a wide range of questions and complaints on its hotline, many of which require substantial knowledge about the operations of individual health care plans or knowledge about appropriate medical treatments. For example, in recent months, DMHC’s hotline reports the following types of issues:

- Consumers calling with concerns about the negotiations between Blue Cross and Sutter;
- Hundreds of calls from a particular plan’s enrollees with concerns about the transfer of their medical records;
- Calls from providers wondering how to obtain payment from medical groups that have filed for bankruptcy;
- Providers calling about unpaid claims from medical groups;
- Urgent complaints requiring immediate resolution regarding
 - Out-of-Network problems;
 - Denial of coverage;
 - Delay/denial of treatment;
 - Delay/denial of medication;
 - Denial of referral;
 - Equipment issues;
 - Premature hospital release;
 - Delays in obtaining appointments;
 - Inappropriate care;
 - Facility location concerns.

With respect to those calls that involve complaints (instead of mere questions), about one-third of DMHC’s hotline complaints involve billing disputes, another one-third involve benefit or coverage problems, twenty percent involve access to care issues, and three percent involve quality of care issues, and the remaining thirteen percent fall into an “other” category. Section 1368 of the Health and Safety Code establishes a procedure and timeline for the submission and resolution of grievances to

DMHC. In general, grievances are to be resolved by DMHC “within 30 calendar days of receipt of the request for review.” Health & Safety Code § 1368(b)(5).

Some of the individual anecdotes reported by DMHC’s hotline are similar to issues handled by CDI’s hotline. For example, one consumer filed an appeal with his health plan for a previously denied claim. The plan reversed their prior decision and agreed to pay the claim. But the enrollee later received a collection letter when payment was not received. The hotline staff called the plan and discovered the claim had been approved, and staff then contacted the collection agency on the enrollee’s behalf to ensure appropriate processing.

However, many individual anecdotes from DMHC’s hotline confirms that it handles very different types of problems than CDI’s hotline. One consumer called the hotline asking for help in obtaining her medical records. She was unable to see her new primary care physician since her medical records were unavailable from her now-bankrupt medical group. CDI’s jurisdiction and expertise does not generally encompass this type of consumer problem. However, because of DMHC’s broader jurisdiction over plans, its hotline staff contacted the health plan representative, learned that the plan had contracted with a third party to obtain medical records from the bankrupt medical group, and secured the plan’s agreement to submit an expedited request for the transfer of the records to the consumer’s new primary care physician.

Another caller reported difficulty in getting reports from an MRI of his lower lumbar forwarded from an orthopedic surgeon to another specialist for a second opinion. The hotline operator called the plan and discovered that the plan could not require the first physician to send the records to the new specialist. The operator then called the enrollee’s primary care physician and explained the situation. The primary care physician requested the records from the uncooperative surgeon and upon receipt, forwarded them to the new specialist.

As these anecdotes make clear, DMHC’s hotline is fully exercising DMHC’s broad jurisdiction over plans which have agreed to provide medical services. When problems in the delivery of those services arise, DMHC can respond by reaching out directly to plans and providers.

2. CDI’s Consumer Assistance Hotline

The CDI consumer assistance hotline is operated in Los Angeles by the Consumer Communications Bureau within the Department's Consumer Services & Market Conduct Branch. The CDI hotline number is 800-927-HELP. The hotline operates from 8:00 a.m. to 6:00 p.m., Monday through Friday except for holidays. The hotline serves as an information clearinghouse for consumers with insurance-related questions or problems. Staffed by insurance experts, the hotline endeavors to provide immediate assistance to callers whenever possible.

CDI's hotline is supervised by a bureau chief who reports to the Deputy Director of the Consumer Services & Market Conduct Branch.

In 2000, the CDI hotline received 422,364 calls. The subject matter of these calls was as follows:

20%	81,637	Verifying insurance co. information
7%	28,543	CDI phone # on policy
5%	23,101	General insurance requests
2%	10,346	Claims regulation information requests
2%	9,526	Private passenger auto
2%	9,013	Consumer request for producer information
2%	8,468	Health insurance
1%	5,511	HMO referral to DMHC
1%	5,294	Producer requests for license information
1%	4,583	Credit insurance
0%	1,520	Homeowners
57%	234,822	Other -- Various lines of coverage / short term subject data

From this data, we can see that CDI's hotline logs about 14,000 health-related calls per year, and almost 40% of those calls must be re-directed to DMHC. About 8,500 health-related calls per year fall within CDI's regulatory jurisdiction, which is about the same as the number of calls which DMHC hotline operators handle per month. A word of caution about this data is in order. Some calls that actually are health-related are coded under *other* categories, and the total number of calls logged as health-related understates to some extent the total number of health-related calls.

Consumers' apparent confusion over whether to call CDI or DMHC for

assistance with health insurance issues has been repeatedly cited as one of the problems that might be solved by transferring jurisdiction over health insurance products from CDI to DMHC. If CDI had *no* regulatory jurisdiction over health insurance, then *all* callers to CDI's hotline could be immediately referred to DMHC's hotline. By contrast, so long as CDI maintains jurisdiction over some health insurance products, consumers who call CDI will have to answer certain questions for the CDI operator to decide whether the caller can be helped by CDI or needs to contact DMHC. (There are other options for addressing the problem of consumers not knowing which government agency to call for help, and these options are discussed in greater detail in chapter III.)

CDI reports the following type of health care complaints which are handled by its hotline:

- Denial of claims;
- Claim handling delay;
- Delay of pre-authorization for services needed;
- Failure to provide payment for pre-authorized services;
- Unexpected reductions in benefits;
- Coordination of benefits conflicts;
- Lack of clarity concerning what benefits are covered;
- Determination of usual and customary charges;
- Failure to notify insured of continuation of coverage rights under Cal-COBRA and/or HIPAA (conversion rights);
- Delay or failure to respond to inquiries;
- Refusal to insure;
- Rescission of coverage;
- Retroactive cancellations (non-payment of premium);
- Excessive premium increases;
- Unexpected changes in contract provisions B lack of adequate notice;
- Improper agent handling;
- Misrepresentation;
- Termination of coverage.

It appears that many of these complaints are more insurance-related than health-related, at least in the sense that resolution of the complaint does not require any

knowledge about the insured's medical condition and is not immediately necessary to protect the insured's health.

If a consumer call matures into a complaint, CDI's "Insurance Compliance Officers" contact companies and agents directly to investigate and resolve consumer complaints. The officers also review the files and records of insurance companies and agents to determine whether the issues raised by consumers were properly handled and, further to identify violations of insurance laws and regulations. Additionally, officers recommend enforcement action and on-site field examinations of insurance companies based on frequency and/or severity of violations discovered.

CDI's hotline is staffed by experts in the field of insurance. Most of the hotline staff employees have college degrees, and many have participated in continuing education programs to obtain special insurance certifications and designations. CDI does not employ any medical or clinical staff for its hotline since it does not resolve clinical questions dealing with medical necessity or experimental or investigational treatments. Under the recently-created Independent Medical Review system, discussed below, consumers who disagree with an insurer's determinations regarding medical necessity or experimental or investigational treatments may now have that dispute referred to an independent entity for resolution.

CDI indicates in its Strategic Plan 2001 that it plans to purchase a new Consumer Hotline telephone system that will improve and expand service capabilities.

G. Independent Medical Review

Managed care organizations attempt to manage and limit costs by focusing greater attention upon the decision of whether a patient actually needs particular medical services and by restricting the use of experimental or investigational services. From the plan perspective, these controls and restrictions are required as an antidote to overly-defensive medical practices that had developed under fee for service systems in response to the threat of medical malpractice actions. From the patient's perspective, these controls and restrictions may help keep costs down, but at the risk of denying potentially necessary medical treatment. Meanwhile, the physician may face a conflict between what is economically and contractually permissible and the independent judgment that society expects a physician to employ.

In the face of mounting criticism, some health plans, legislatures and regulators have responded by creating Independent Medical Review (“IMR”) systems which guarantee to patients access to an independent review of plan decisions to deny, terminate or limit health care services. IMR is now a widely accepted consumer protection for patients in managed care systems. It ensures that decisions about access to medical services are based on medical evidence and generally accepted practice standards and not on economic pressures to reduce costs.

The IMR system in California began in 1996 with enactment of the Friedman-Knowles Experimental Treatment Act of 1996. 1996 Cal. Stats., ch. 979 (codified at Health & Safety Code § 1370.4 and Ins. Code § 10145.3). Under Friedman-Knowles, an enrollee or insured with a terminal medical condition could request an independent review if the plan or insurer denied coverage for a recommended treatment because the treatment was experimental or investigational. This limited statutory IMR system was subsequently expanded to encompass both life-threatening or seriously debilitating conditions. 1999 Cal. Stats., ch. 542 (SB 189, Schiff).

In 1999, AB 55 (Migden) further expanded the IMR system to encompass plan or insurer denials based on medical necessity. 1999 Cal. Stats., ch. 533 (codified at Health & Safety Code §§ 1374.30 through 1374.35 and Ins. Code §§ 10169 through 10169.5).³

³ As an aside, it is worth noting that the IMR statutes are now confusingly split up within the Health & Safety Code and Insurance Code. The provisions dealing with experimental and investigational decisions are buried in the middle of Article 5 in the Health & Safety Code dealing with “Standards” and at Section 10145.3 of the Insurance Code. The provisions dealing with medical necessity determinations are found in a separate article of the Health & Safety Code, Article 5.55, devoted exclusively to independent medical review, and in a separate article in the Insurance Code. DMHC and CDI should explore a technical clean-up of the statutes so that *all* of the IMR provisions are consolidated within each code or, better

1. DMHC's IMR System

DMHC has entered into a contract with an accredited professional review organization, the Center for Health Dispute Resolution, to conduct the independent reviews. This organization has panels of pre-screened medical specialists available to provide the analyses and determinations required by the IMR system. After screening for conflicts of interest (*see* Health & Safety Code § 1374.32), panel members are selected for individual cases based upon their professional and clinical expertise. DMHC expects to enter into similar contracts with additional review organizations. DMHC is receiving around 70-90 applications for IMR every month.

The cost of the IMR system is paid directly by the state, but this cost is reimbursed by the plans based on the utilization of IMR by their enrollees. In particular, the costs of the reviews are periodically reimbursed by the plans; the overall administrative costs of the IMR system are reimbursed by assessments paid by all licensed plans. Health & Safety Code § 1374.35.

The IMR system handles three types of disputes:

- Experimental or investigational therapies that are delayed, denied or modified by the plan when the patient is diagnosed with a life-threatening or seriously debilitating condition (Health & Safety Code § 1370.4);
- All other covered medical services that are delayed, denied or modified by the plan based in whole or in part on a finding that the services are not medically necessary (Health & Safety Code § 1374.30(j)(1)(A));
- Denied reimbursements for an enrollee's out of plan emergency or urgent care services (Health & Safety Code § 1374.30(j)(1)(B)).

Before appealing to the IMR system, an enrollee generally must participate in the plan's grievance process. In most cases, the enrollee may appeal only if the disputed decision has been upheld or the grievance remains unresolved after 30 days.

yet, all provisions dealing with grievance procedures are placed together in each code.

Health & Safety Code § 1374.30(j). In cases requiring expedited review where there is an imminent and serious threat to the health of the patient (Health & Safety Code § 1368.01(b)), the enrollee may appeal if the grievance remains unresolved after three days (Health & Safety Code § 1374.30(j)).

When a plan notifies an enrollee regarding a disposition of the enrollee's grievance that denies, modifies or delays health care services, the plan must provide the enrollee with a one-page application form approved by DMHC, and an addressed envelope, which the enrollee may return to DMHC to initiate an independent medical review. Health & Safety Code § 1374.30(m).

When DMHC receives an application for IMR, it notifies the plan of the application, and the plan is then required to produce all relevant medical information to the entity which will conduct the IMR. The enrollee is also permitted to submit information for consideration. A decision must be reached by the IMR panel no later than 30 days after receipt of the application, and in cases requiring expedited treatment, no later than 3 day after receipt of the application. Health & Safety Code § 1374.33(c).

If the IMR panel determines that a disputed health care service is medically necessary, or that a treatment is not experimental or investigatory, the plan must promptly implement the decision by providing the service or, if services have already been provided, appropriate reimbursement for the service. Health & Safety Code § 1374.34(a).

2. CDI's IMR System

As noted above, the Legislature enacted parallel provisions in the Insurance Code to require IMR systems for denials of coverage based on findings of no medical necessity or that a treatment is experimental or investigational. Ins. Code §§ 10145.3 & 10169 through 10169.5. These parallel provisions are designed to provide to patients the same substantive protections whether a patient receives health care services provided by a plan regulated by DMHC or receives health care services that are reimbursed under a contract of insurance regulated by CDI. Most important, insurance companies are required to advise insureds in writing about the availability of the IMR process at the time the policy is sold or if the policy is amended or renewed after January 1, 2000. In addition, the insurer must advise the insured of the IMR system when a benefit is delayed, reduced, or denied.

Recognizing that inefficiencies and inequities might result from having two separate departments administer virtually identical programs, the Legislature expressly provided in Section 10169.5(c) of the Insurance Code that the Insurance Commissioner “may contract with the Department of Managed Health Care to administer the requirements of this article.” The Insurance Commissioner has exercised this power by entering into a contract to have DMHC administer CDI’s IMR system. Section 10145.3 of the Insurance Code, which deals with experimental or investigational therapies, expressly provides that an insurer’s decisions are subject to the IMR system established in the Health and Safety Code. Ins. Code § 10145.3(b). This collaborative approach, pursuant to which CDI’s IMR system is administered by DMHC, helps to ensure that the IMR system will be uniformly applied to plan denials, modifications or delays, and to insurer refusals to cover or reimburse.

In contrast to DMHC, which has been receiving a steady stream of applications for IMR, so far, only a handful of IMR claims have been filed with CDI. CDI should take appropriate steps to ensure that insureds are being made aware of their right to seek IMR, and CDI should consider studying the use of IMR by policyholders who are covered by disability policies.

H. Quality of Care and Market Conduct Examinations

1. CDI’s Limited Review of Quality of Care

CDI engages in virtually no review of quality of care issues. With respect to pure indemnity health insurance, there is virtually no reason for CDI to expend any resources on quality of care. Consumers have virtually unlimited choice of providers, and other agencies engage in various levels of licensure, oversight and certification. As noted above, the situation is only slightly different with respect to indemnity-PPOs since, assuming consumers have a genuine choice to go out-of-network and the in-network is sufficiently large, the choice of provider still lies with the consumer.

EPOs are in a different class, as explained above, and Section 10133(d) and CDI regulations purport to assure some measure of quality control. However, CDI’s regulations regarding EPOs have not been substantially updated since their enactment almost twenty years ago, and it is unclear the extent to which CDI even enforces these regulations. Admittedly, non-compliance may show up during a CDI field

examination, but enforcement of this sort is more serendipitous than systematic.

Although CDI does not systematically examine quality of care issues, CDI does have substantial programs that examine an insurer's market and claims handling practices. The Market Conduct Bureau performs examinations of insurer claims handling and settlement practices to ensure conformity with the unfair claims and settlement practices statutes and regulations. The Field Rating & Underwriting Bureau examines insurer marketing, risk selection, and pricing practices. Examinations by either bureau may be done either on-site or through the collection and analysis of data and documentation. Both bureaus conduct exams of all regulated lines of business.

Examinations include a review of the insurer's rules, guidelines and procedures and then a detailed review of claims or underwriting files to determine if the insurer's actions are consistent with its adopted rules and applicable California law. Every alleged violation identified by the examiners is communicated to the insurer for resolution. Insurers are required to implement corrective processes to correct any trends in noncompliance that are discovered during the exam. This includes returning premium overcharges, paying additional amounts on claims, and taking steps to prevent future noncompliance through additional training of the insurer staff, addition of new staff, or adoption of new procedures. CDI maintains general guidelines to identify those examinations that warrant legal action. Generally, this includes examinations where one or more criticisms of the insurer are unresolved, or where there is evidence of willful noncompliance, or where there are one or more trends of noncompliance which result in a harmful impact on the consumer.

2. DMHC's Quality of Care Programs

One of DMHC's primary functions is to ensure appropriate quality of care in health plans subject to its jurisdiction. Responsibility over quality of care issues lies primarily within DMHC's Division of Health Plan Standards, which is responsible for handling actions involving health plans' compliance with the non-financial requirements of the managed health care laws, including the quality, accessibility, and continuity of care, and its Division of Plan Surveys, which is responsible for evaluating and promoting health plan regulatory compliance and quality improvement as related to health care delivery systems.

Section 1380 of the Health and Safety Code requires that DMHC "conduct

periodically an onsite medical survey of the health delivery system of each plan. The survey shall include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.”

DMHC performs surveys using both its own staff of analysts, most of whom have been registered nurses, and third party experts. For example, the UCLA School of Dentistry conducts on-site surveys of dental plans. DMHC also has a contract with Managed Healthcare Unlimited to conduct on-site surveys of ten full-service plans, and this contractor also assists in developing performance standards, measurement criteria, survey tools and reporting formats.

DMHC’s routine surveys of plans are scheduled to occur once every three years with a follow-up review within 18 months of the final survey report. Non-routine surveys, which may be triggered by unusual events, reports from the hotline, or reports from other divisions within DMHC, occur as often as necessary.

Providers have for quite some time complained about the burdens imposed upon them by duplicative, overlapping medical audits. Based in part upon the report of a Department of Health Services working group titled, “Reducing Duplicative Provider Audits: A Strategic Blue Print for Action” (Dec. 1999), the Legislature has directed the Advisory Committee on Managed Care to “recommend to the director standards for a uniform medical quality audit system, which shall include a single periodic medical quality audit. The director shall publish proposed regulations in that regard on or before January 1, 2002.” Health & Safety Code § 1380.1(b).

I. Solvency Regulation

Both CDI and DMHC are responsible for ensuring the financial sustainability over time of the regulated entities within their respective jurisdictions. Solvency regulation is not for the benefit of the insurer or health plan. Rather, the assurance that an insurer or health plan will still be around to provide the promised reimbursement or health service is a critically important consumer protection.

Solvency regulation generally falls into two functions. First, CDI and DMHC must continually monitor the financial health of their regulated entities, and when

warning signs develop with respect to a particular insurer or plan, the regulator must intercede to make sure that appropriate steps are taken to restore the insurer or plan to fiscal health. Second, when an insurer or plan fails, CDI and DMHC must exercise their regulatory authority to reduce or eliminate the harm to the failed insurer's or plan's consumers.

1. CDI's Financial Surveillance Program -- Risk-Based Capital

CDI's Financial Surveillance Branch consists of two divisions. The Financial Analysis Division evaluates and monitors the financial condition of insurance companies to identify problem companies and takes corrective actions or recommends regulatory actions to assure insurer solvency for the protection of consumers. The Field Examination Division protects policyholders by conducting comprehensive financial examinations of California's domiciled insurance companies and other insurance organizations to determine their financial solvency and capacity to meet policyholder obligations. CDI's Financial Surveillance Branch exchanges information with insurance regulators around the country, and there is a substantial amount of collaboration and cooperation among regulators in handling troubled companies.

Departments of insurance in nearly all states, including California (Ins. Code §§ 739-739.12), rely upon nationally-developed risk-based capital models in tracking the financial health of insurance companies. These quantitative models, which are developed and maintained by the National Association of Insurance Commissioners, establish a hypothetical minimum capital level that is then compared to a company's actual capital level. The system has five ratio levels that regulators use to determine what action, if any, may be necessary to maintain an insurer's viability:

Action Level	Ratio of Total Adjusted Capital to Minimum Risk-Based Capital	Type of Action
No Action Level	2.0 or Greater	No action required
Company Action Level	1.5 or Greater and Less Than 2.0	Insurer must prepare report to regulator outlining the corrective actions the company

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		intends to take.
Regulatory Action Level	1.0 or Greater and Less Than 1.5	Insurer must file an action plan, regulator is required to conduct examinations, and regulator may issue corrective orders.
Authorized Control Level	0.7 or Greater and Less Than 1.0	Regulator is authorized to take control of the insurer.
Mandatory Control Level	Less Than 0.7	Regulator is required to take steps to place insurer under control.

Separate risk-based capital models apply to life insurance, property and casualty, and health insurance. The different models reflect differences in the economic environments of these markets. However, all of the models involve a complex calculation that incorporates an analysis of Asset Risk-Affiliates, Asset Risk-Other, Business Risk, and Underwriting Risk. Asset Risk-Affiliates refers to the risk of default of assets for affiliated investments (i.e., the risk-based capital requirements of downstream insurance subsidiaries owned by the insurer). Asset Risk-Other represents the risk of default for debt assets (e.g., bonds, mortgages and short-term investments) and loss in market value of equity assets (e.g., common and preferred stock, real estate, and long-term assets).

Business Risk refers to the wide range of general business risks faced by an insurer. The characteristics of these risks are difficult to quantify in a general way for all companies and lines of business. Health insurers are subject to a business risk calculation that deals with risks such as the variability of operating expenses, collectibility of payments for administering third party programs, and excessive growth. These sub-components recognize that instability can result from poor controls on administrative expenses as well as from instability in medical expenses.

The Underwriting Risk, also known as the insurance risk, encompasses an analysis of reserve risks (i.e., risks of excess claims because of fluctuations in

frequency and severity of claims) and premium risks (i.e., risks that premium is not high enough to pay for future losses). Beginning in 1993, the National Association of Insurance Commissioners began developing a risk-based formula for health care plans, and the first version of that formula was adopted in 1998. The predominant risk faced by managed care organizations is that medical expenses will cost more than the premiums collected to pay those claims. The managed care organizations formula recognizes that larger blocks of business will have relatively less fluctuations, and therefore, tiered factors are used to recognize the increased stability that comes with higher volume. The managed care formula also includes an adjustment to recognize the beneficial effect of managed care arrangements in decreasing the fluctuations in medical expenses.

In the event of an insolvency, unpaid claims may be paid by the California Life and Health Insurance Guarantee Association. Ins. Code §§ 1067-1067.18. The association was “created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purposes” of the association. Ins. Code § 1067.01(b).

2. DMHC’s Financial Surveillance Program -- Tangible Net Equity

DMHC’s Division of Financial Oversight conducts examinations of the fiscal and administrative affairs of health care service plans to protect consumers and providers from the calamities associated with potential insolvencies. The financial examination reviews such items as cash flow, premium receivables, intercompany transactions and medical liabilities. The examination also ensures that there is compliance with claims paid requirements, the calculation of tangible net equity, that there is appropriate insurance in place, and that there are procedures to monitor the financial viability of capitated providers. DMHC has authority to impose monetary fines, issue cease and desist orders, seek injunctions, appoint receivers or conservators, or revoke licenses. As part of its early warning process, DMHC may require submission of audited financial statements covering the preceding 12-months. Health & Safety Code § 1384(a).

Section 1376(a) of the Health and Safety Code authorizes DMHC to enact rules and regulations “to provide safeguards with respect to the financial responsibility of plans,” and, in particular, to “require a minimum capital or net worth,” among other things. DMHC’s regulations require that each plan “shall, at all times, have and

maintain a tangible net equity” at least equal to a calculated minimum. 28 Cal. Admin. Code § 1300.76(a). For full service plans, the minimum is the greater of (1) \$1,000,000; or (2) the sum of 2% of the first \$150 million of annualized premium revenues plus 1% of annualized premium revenues in excess of \$150 million; or (3) specified percentages of annualized health care expenditures. 298 Cal. Admin. Code § 1300.76(a)(1)-(3).

There is no simple way of comparing DMHC’s financial surveillance program, including its tangible net equity requirements, with CDI’s surveillance program. The methodologies are so completely different that a direct comparison is not possible. However, there is no doubt that the risk-based capital methodology, which is a central feature of CDI’s program, is more finely tuned than the tangible net equity system, and the risk-based capital methodology requires an analysis that better reflects individual differences between insurers. As a generality, it appears that the risk-based capital system imposes great capital requirements upon insurers than would be imposed under the tangible net equity approach, with some estimates suggesting that the risk-based capital system imposes up to 2 times the capital requirements as tangible net equity.

Many plans transfer the risk of loss on the provision of medical services from themselves to independent medical groups pursuant to contracts that pay the group on a capitated or other fixed periodic payment basis. These independent medical groups may take many organizational forms, including professional medical corporations, corporations controlled by physicians and surgeons, medical partnerships, medical foundations, or other formally organized group of physicians that delivers, furnishes or otherwise arranges for or provides health care services (excluding, of course, health care service plans). Health & Safety Code § 1375.4(g)(1).

Independent medical groups do not qualify as plans under the Knox-Keene Act and are therefore not required to secure a license from DMHC to operate. In addition, although independent medical groups are clearly risk-bearing entities, in the sense that a medical group is contractually obligated to provide medical services that fall within the scope of the plan’s obligations to its enrollees even if those services must be provided at an economic loss to the medical group, medical groups are *not* regulated by CDI even though it might appear the contract between the plan and the medical group essentially indemnifies the plan against liabilities arising from contingent or unknown claims by the plan’s enrollees (and, thus, is technically a contract of “insurance” under Section 22 of the Insurance Code).

In part, perhaps, because independent medical groups were not regulated by either DMHC or CDI, some independent medical groups in recent years took too much risk upon themselves in light of their assets and resources and have become insolvent. In 1999, the Legislature responded to this risk to plan enrollees by enacting SB 260 (Speier) which created the Financial Solvency Standards Board within DMHC and required the Board and DMHC to begin regulating risk-bearing independent medical groups indirectly by requiring plans to meet certain standards in their contracts with independent medical groups. For example, Section 1375.4(a) of the Health and Safety Code requires that every contract between a plan and risk-bearing medical group include terms requiring that the medical group supply certain financial information to the plan to assist the plan in maintaining the viability of its arrangements for the provision of health care services to its enrollees, and that the plan disclose certain information to the group to enable it to become properly informed about the financial risks assumed under the contract. SB 260 also required DMHC to enact implementing regulations to review or grade risk-bearing medical groups and required the Solvency Board to make recommendations to DMHC for additional regulatory safeguards. The Solvency Board may wish to consider adopting the risk-based capital methodology developed by the National Association of Insurance Commissioners.

In the event of an insolvency, enrollees are allocated by DMHC to other health care plans which have sufficient financial and administrative capacity and which operate within at least a portion of the service area of the insolvent plan. Health & Safety Code §§ 1394.7 & 1394.8. In the process, enrollees may be forced to accept new physicians, and providers may have difficulty in collecting claims.

J. Taxes

Insurers generally pay a tax based upon gross premiums received which is known as the “premium tax.” The premium tax is 2.35% of annual gross premiums. Rev. & Tax. Code §§ 12202 & 12221. The premium tax is in lieu of all other taxes and licenses, state, county, and municipal upon insurers and their property with certain specified exceptions (e.g., taxes upon real estate and DMV license fees). Rev. & Tax. Code § 12204. In fiscal year 1999-2000, the premium tax produced \$1.30 billion in revenue for the State’s general fund. The estimated revenue for the premium tax for fiscal year 2000-2001 is \$1.33 billion, and the estimate for 2001-2002 is \$1.35 billion.

Health care plans are subject to California's general tax on corporations. Unless otherwise provided by law, corporations doing business or incorporated in California must pay a franchise tax equal to the greater of the minimum franchise tax of \$800 (Rev. & Tax. Code § 23153(d)) or an amount measured by net income multiplied by the current tax rate, which is 8.84 percent (Rev. & Tax. Code § 23151).

Although the corporations tax rate of 8.84% is higher than the premium tax rate of 2.35%, because the base for the premium tax is gross premiums instead of net income, the premium tax collects a greater share of an insurance company's premium revenue than is proportionately collected from a health plan by the corporations tax. Trying to determine the relative burdens of these two taxes is an extraordinarily difficult proposition. A 1990 study sponsored by the Association of California Life Insurance Companies attempted such a comparison by surveying its members regarding their federal taxable income as adjusted for operating loss deductions, tax exempt interest, and dividends received deductions, all of which vary for federal and California state income tax purposes. This and other data was combined to calculate an equivalent tax burden on life insurance companies ranging from a low of 8.7% in 1984 to a high of 30.5% in 1987 with an average of 15.7% for the period 1984 through 1987. Based on this study, it has been generally estimated that the premium tax imposes an effective tax rate of about twice the corporation's tax.

If the jurisdiction to regulate health insurance products were transferred from CDI to DMHC, the premiums for those products would no longer be taxable pursuant to the Insurance Code's premium tax. Instead, that revenue stream would contribute to net income and be taxed by the corporations tax. As a result, the tax revenue from the economic activity generated by these products would arguably be cut roughly in half. However, it must be emphasized that the comparison here is *very* rough because the actual decrease in tax revenue would depend on quite a few factors other than simply the effective tax rate.

Moreover, it is even difficult to estimate how much revenue is generated from health insurance premiums because CDI, which is responsible for collecting the premium tax, does not differentiate in its tax data between different lines of insurance. However, a rough estimate of the impact can be made based upon the total annual premium for all lines of insurance, the total premium tax collected, and an estimate of the annual premium for health and disability lines of insurance. The total premium is approximately \$86.4 billion, and the premium tax produced about \$1.30 billion in

1999-2000. Health premiums are estimated at about \$6.8 billion annually, which suggests that approximately \$102 million of the total premium tax collected is attributable to health insurance. If jurisdiction over these products were transferred to DMHC, we can expect a decrease in tax revenues of approximately \$50 million annually. The decrease would of course be larger if a significant number of the companies currently offering health and disability insurance decided to withdraw from the market entirely rather than continue to offer products under the jurisdiction of DMHC.

In view of the great complexity of this subject, further study of the possible tax consequences resulting from jurisdictional changes is appropriate. DMHC and CDI should jointly seek the assistance of the Franchise Tax Board and other experts to assist in developing a more accurate assessment of possible tax revenue consequences.

Chapter III.

Options for Reform of Regulatory Jurisdiction

I present in this chapter several options for reform of regulatory jurisdiction. Although I have endeavored to present these options as neutrally as possible, it is inevitable that some of my own value judgments have influenced my perceptions. With that caveat, I offer the following observations about regulatory jurisdiction reform:

First, there seems to be general agreement that consumers and others are understandably confused about the identity of the appropriate regulator and may become frustrated upon calling one department for help only to discover that another agency has jurisdiction. Everyone agrees that this problem should be addressed.

Second, there seems to be general agreement that certain types of consumer protections should apply equally whether dealing with an HMO regulated by the Department of Managed Health Care or an indemnity or indemnity-PPO regulated by the Department of Insurance. This is consistent with the trend of some recent legislative activity in this area to draft parallel statutes for the two departments. The protections most frequently mentioned are independent medical review and grievance procedures with timelines and notification deadlines. But there obviously are many other consumer protection issues including such things as continuity of care and solvency protection.

Third, I have discovered in my interviews what I would describe as an information gap. Some people who have been focusing their energies over the last decade upon development of public policy related to managed care may not have a fully developed understanding of the laws and public policies that underlie regulation of insurance products. Others who have been focused on insurance regulation may have a similar lack of understanding about the regulation of the managed care industry. Part of the value of this regulatory study is to fill in those gaps so that all stakeholders can appreciate the actual differences in the regulatory environment and whether those differences are justified in light of differences in the products being offered and in the nature of the business.

My general sense is that everyone would be a little happier *in theory* if there were just one regulator. Most seem to agree that it is a little awkward to have two regulators, one appointed by the Governor and the other independently elected, with

somewhat overlapping jurisdiction over somewhat similar products that compete in many of the same markets. Among other things, there is a potential for getting different answers to questions that should probably have a single answer.

Although a single regulator would be preferable *in theory* (or, alternatively, two regulators both of whom were appointed by and accountable to the same person), there is substantial disagreement about whether that can or should be achieved in California *in practice* given the existing bifurcation of authority between the Department of Managed Health Care and the Department of Insurance. It is worth remembering that regulatory jurisdiction over health insurance and health plans has been divided for over sixty years in California, first between CDI and the Attorney General, and then between CDI and the Department of Corporations (and now DMHC).

The fact that jurisdiction has been divided from virtually the inception of health care service plans in California may suggest that there is really no pressing need for regulatory consolidation at this moment. Arguably, consolidation may only marginally improve regulatory consistency, but at the possible cost of over-burdening an already rapidly expanding agency, DMHC, that finds itself very much in the public spotlight, and at the possible cost of causing some health insurance products to exit the market. On the other hand, in light of bureaucratic stasis and political reality, substantial organizational and regulatory change in government usually must take place opportunistically, for example in response to one or more flash points (such as major scandals in an industry or agency), because political considerations make organizational change possible during a brief period of time, or because of a carefully cultivated consensus for change.

We turn now to several regulatory reform options for consideration. These are not intended to be the only options which are worthy of consideration, and the options are not mutually exclusive of each other. One or more features from one option may be combined with features from other options. However, it appears that clarity of analysis can be advanced by considering the following options:

- Equalizing Hotline Performance Without Altering CDI's or DMHC's Regulatory Jurisdiction
- Equalizing Other Consumer Protections Without Altering CDI's or DMHC's Regulatory Jurisdiction
- Functional Regulation With Each Agency Having Regulatory Jurisdiction Over Certain Aspects of Health Insurers and Health Care Plans
- DMHC Jurisdiction Over All Health Insurance
- DMHC Jurisdiction Over All EPOs and/or PPOs

A. Equalizing Hotline Performance Without Altering CDI's or DMHC's Regulatory Jurisdiction

The first two options, equalizing hotline performance and equalizing other consumer protections (discussed in the next section), maintain each agency's regulatory jurisdiction while making certain statutory and regulatory changes so that both agencies protect consumers' rights and interests to roughly the same extent. These issues could be handled without changing the regulatory jurisdiction of either agency by greater voluntary collaboration between the agencies or more formal memorandums of understanding, and by statutory changes to equalize certain protections.

Consumer confusion over who to call for help is caused by many considerations, some of which will continue to cause confusion even with regulatory jurisdiction reform. The most obvious cause of confusion is that products commonly known to the public by the name of "health insurance" are not regulated by the Department of Insurance or by the Department of Health Services, but are regulated by a newly-created agency, the Department of Managed Health Care, which is the successor to a division within the Department of Corporations. A consumer who does not know who to call in advance and who has not been given the proper phone number by his or her insurer or health care plan is likely to turn to a traditional source of information for help, the Government Pages in the White Pages telephone directory. The Sacramento Pacific Bell White Pages for 2001-2002 does *not* list the Department of Managed Health Care, probably since DMHC was only recently created. Instead, the listings on the page where DMHC should appear include the Health Facilities Financing Authority, Health Services Department, Insurance Department, Labor Commissioner, Medical Assistance Commission, Medical Board of California, Mental

Health Department, Nurses, Nurses Vocational & Psychiatric Technician Examiners Board, the Nursing Home Administrators State Board of Examiners, the Board of Optometry, and the Osteopathic Medical Board. Is it any wonder that consumers right now may be confused?

The absence of a telephone directory listing is obviously a short term problem, and DMHC has a long term strategy to become better known. DMHC's marketing and branding efforts include the publication of a very friendly website, attractive brochures, refrigerator magnets with DMHC's 800 number, and television advertisements. These are worthy efforts, and they ultimately may succeed in substantially reducing consumer confusion. However, developing and maintaining general tradename recognition among consumers in the marketplace is always a challenge, and there may be other initiatives that can also reduce confusion.

One of the most important efforts is to ensure that DMHC's hotline number is made available to patients by health care plans at the time when patients are most likely to need help: i.e., upon denial, delay or modification of treatment. Section 1368.02 of the Health and Safety Code already requires plans to publish the hotline number "on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances." This is similar to a requirement that insurers publish CDI's hotline number on all correspondence with insureds. Yet CDI's experience has been that insurers often violate this requirement.

The first thing that both CDI and DMHC can do to reduce confusion is to step up enforcement of existing requirements regarding notice of the appropriate hotline number and to consider expanding those requirements, if necessary. Violations of these requirements must be met with immediate and substantial fines.

Second, it appears that most of the wrong numbers requiring transfer are calls to CDI that must be routed to DMHC (and not the other way around). Some of the callers to CDI are apparently given DMHC's hotline number and asked to call that number. This forces a consumer who may already have told his or her story once to a CDI operator to hang up, dial a new number, and retell the entire story again. While this may not seem to be a particularly onerous burden, a consumer faced with the anxiety,

uncertainty and confusion regarding an immediate health care problem could simply give up when faced with a “bureaucratic run around” and is very likely to feel anger and frustration at the additional delay and inconvenience of finding the right regulator. One option is for all health-related calls placed to CDI’s hotline to be diverted to DMHC’s hotline (which could be accomplished automatically based on the initial menu of options given to consumers who call CDI’s hotline). In the alternative, CDI should consider adopting a requirement that CDI operators in Los Angeles conference-in a DMHC operator in Sacramento so that the consumer receives a continuity of hotline service.

Third, many observers and stakeholders have recommended that CDI’s and DMHC’s health care hotlines be consolidated in some manner so that there is only *one* health care hotline where each call could be “triaged” to determine the appropriate regulatory response. Diversion to the appropriate regulator (CDI or DMHC) would be done by the “experts,” rather than requiring the consumer to figure out which number to call or giving a telephonic menu choice to pick. In addition to reduced consumer confusion, such a consolidation could make available in one place standardized data tracking capability for managed care complaints, whether against HMOs or PPOs. While the extent to which one primary health insurance and managed health care hotline would achieve these results is unclear, it is an option worth considering. Two possible approaches to establishing a single hotline are as follows:

(1) Establish an entirely new hotline number for all health insurance and managed care calls where calls to that single hotline are then diverted to the appropriate agency for action. If CDI’s and DMHC’s jurisdiction remains unchanged, which is the assumption in this model, both agencies may need to maintain their own hotline numbers for health insurance issues falling within their respective jurisdictions, and a single hotline number for health issues would add another number which could further confuse consumers. On the other hand, over time and with public education, a new number could become widely known.

(2) Use DMHC’s hotline number, public recognition of which currently is being actively promoted, as the main managed care and health insurance hotline. This may make the most sense since wrong numbers to CDI far outnumber those to DMHC, indicating that most callers need to end up at DMHC. Using the DMHC hotline as the primary one presents at least two options. DMHC staff could triage calls and route to CDI those within CDI’s jurisdiction. As suggested above for CDI, DMHC could

conference in CDI staff so the consumer receives continuity of service. Alternatively, DMHC's operators could be trained by CDI to actually handle health insurance calls. The latter option would require a substantial amount of continuing collaboration between DMHC's and CDI's hotline staff and supervisors and may not be workable as a matter of administration. It is, however, an option worth considering.

More broadly, although it seems likely that there will always be multiple hotline phone numbers operated by different agencies which have health care-related oversight responsibility, serious consideration should also be given to selecting one hotline phone number as a statewide "Health Hotline" portal through which consumers could reach any of the other hotline numbers using an automated menu system and specially trained triage operators. The Health Hotline portal could be marketed much more widely and aggressively by all health care agencies as the "one stop shopping" hotline number for *all* health related questions. DMHC should consider whether its existing hotline can serve this broader function without substantially interfering with its core function of responding to health care service plan questions. Even if DMHC's existing hotline cannot serve this function, consideration should be given to creating a new Health Hotline to perform this important function.

Finally, as noted above, the best strategy is to make sure that consumers have the right phone number when they need it. In addition to the existing legal requirements, consideration should be given to requiring that the appropriate hotline number be printed on each medical card. When the card is first issued to an insured or enrollee, the phone number could be prominently highlighted, and over time, insureds and enrollees would become conditioned to checking the card for the hotline number to call. This is not a new idea, of course. One possible objection is that having the number on the medical card is likely to increase dramatically the number of enrollees who would call DMHC within the 30-day period when they should be trying to resolve a grievance with their plan. This would increase the burden on DMHC's hotline and possibly frustrate enrollees. On the other hand, DMHC's hotline already indicates during its automated menu selections that enrollees with a grievance must first contact their plan and attempt to resolve the grievance before contacting DMHC (except in certain emergency situations). Thus, most of these additional phone calls to DMHC are likely to be handled by the automated system. Getting the proper phone number to consumers should be one of the highest priorities, and if printing the phone number on the medical card would serve that purpose, substantial efforts should be made to overcome any difficulties associated with that proposal.

Stakeholder	Pros	Cons
Consumers	Reducing consumer confusion regarding who to call for help regarding health insurance and health care plan problems. No impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent answers to essentially similar hotline questions.
Providers	Reducing confusion regarding who to call for assistance in dealing with insurers and health care plans. No impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent answers to essentially similar hotline questions.
Plans	Reducing consumer confusion and anxiety regarding who to call for help should result in benefit to plans because of more efficient and effective customer service by regulators. No impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent answers to essentially similar hotline questions.
Insurers	Reducing consumer confusion and anxiety regarding who to call for help should result in benefit to insurers because of more efficient and effective customer service by regulators. No impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent answers to essentially similar hotline questions.

B. Equalizing Other Consumer Protections Without Altering CDI's or DMHC's Regulatory Jurisdiction

There are a number of other regulatory issues that could be examined to ensure that consumers receive equal protections irrespective of the identity of the regulator.

The issues include the following regulatory topics:

- Benefit levels
- Quality of Care Monitoring
- Grievance and Dispute Resolution Process
- Solvency Standards

Maintaining consistency with respect to some or all of these regulatory areas will require a substantial amount of cooperation and collaborations between CDI and DMHC. To ensure that such cooperation occurs, the two departments should consider how best to institutionalize collaborative health policy development and implementation in those areas where the departments exercise essentially overlapping or complementary authority.

It is clear that benefit levels, quality of care monitoring, and dispute resolution processes can be appropriately equalized without changing either department's regulatory jurisdiction. Mandated benefit levels are already equalized. The primary difference in benefit requirements are that full service health plans are required to offer basic health care services as minimum benefits, while CDI's insurers have greater flexibility in establishing coverage levels. Equalizing this aspect of benefit levels would be a very significant change in law and policy and would remove from the insurance market a number of specialized products to the detriment of both consumers and insurers.

There are very clearly different quality of care programs at the two departments; CDI does virtually no quality of care monitoring, while DMHC has a substantial quality of care program. In part, this reflects differences in the products being regulated, since pure indemnity health insurance does not lend itself to quality of care regulation. However, CDI also regulates PPOs and EPOs, and while quality of care monitoring of these products is certainly not the same as quality of care monitoring of an HMO (because of the out-of-network feature of PPOs and the size of the inside network), DMHC does engage in some quality of care auditing and monitoring of these products (although there is some question about the extent to which DMHC actually waives its quality of care audits with respect to PPOs). CDI could certainly acquire the necessary expertise, but this seems like a waste of existing resources since CDI would in effect be duplicating skills that already exist at DMHC. Therefore, CDI should explore with DMHC the possibility contracting with DMHC to perform appropriate

monitoring and auditing of quality of care of PPOs and EPOs subject to CDI's jurisdiction.

Consideration should also be given to formalizing in statute clearer requirements of the extent to which PPOs and EPOs should be examined for quality of care. At present, nothing in either the Insurance Code or the Health and Safety Code clearly spells out the scope of this regulatory obligation, and this gap in the statutes is creating some confusion as DMHC endeavors to adapt its HMO quality of care programs for very different types of products.

With respect to dispute resolution systems, the two agencies already have similar systems in place. For grievances short of Independent Medical Review, it appears that DMHC may have a slightly more robust grievance resolution system, probably owing to the statutory requirement that DMHC endeavor to resolve all complaints within 30 days. Consideration should be given to enacting a similar statute with respect to health insurance complaints -- or, perhaps, *all* insurance complaints -- received by CDI. It should be noted that this is not a new issue for CDI. The extent to which CDI's operators can become involved in consumer complaint resolution without adjudicating facts (which CDI is forbidden to do) has been a contentious issue. Now may be a good opportunity to clarify and improve the law and practice with respect to CDI's complaint resolution processes. With respect to complaints or grievances that mature into a request for IMR, the two agencies have already established a collaborative system pursuant to which CDI's IMR obligations are administered by DMHC.

The different solvency standards employed by CDI and DMHC can be equalized only by changing the applicable statutes, and this can be done without changing either CDI's or DMHC's regulatory jurisdiction. CDI is committed, both within the State and nationally through the National Association of Insurance Commissioners, to the risk-based capital system, and it is virtually inconceivable that CDI would abandon that standard today. It appears that DMHC's commitment to the net equity requirement may be somewhat less firmly rooted, and that there may be some room to consider replacing or supplementing the net equity requirement with CDI's risk-based capital system (which has happened in seven or eight other states). DMHC, its Financial Solvency Board, and CDI should jointly examine the merits upgrading the net equity model to a risk-based capital approach.

Caution is in order in equalizing CDI's and DMHC's solvency standards. In particular, replacing or supplementing the net equity system with the risk-based capital system should not be undertaken without a *comprehensive* analysis by CDI's and DMHC's financial experts of how the risk-based capital approach would actually apply to California's health care service plans. The risk-based capital system is likely to impose greater financial burdens on California's health care service plans, and DMHC and the Legislature should be certain before imposing those additional burdens that the payoff in improved financial stability is worth that increased burden on plans.

The pros and cons of equalizing consumer protections while maintaining CDI's and DMHC's regulatory jurisdiction may be summarized as follows:

Stakeholder	Pros	Cons
Consumers	Improving CDI's complaint and grievance process to match the DMHC's process. Improving quality of care and consumer education at CDI. Strengthening solvency of health care plans reduces likelihood of interruption in services. Minimal impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent regulation. Maintaining two regulators risks continued confusion.
Providers	Strengthening solvency of health care plans reduces likelihood of difficulty in payment. Minimal impact upon products currently being offered in the market.	Maintaining two regulators risks inconsistent regulation. Maintaining two regulators risks continued confusion.
Plans	Minimal impact upon products currently being offered in the market.	More intrusive quality of care regulation with respect to PPOs or POSs may increase costs without commensurate improvement in quality of care. Strengthening solvency standards increases costs (but arguably benefits plans in the long run).

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Insurers	Improving CDI's grievance process helps insurer / insured relationship. Minimal impact upon products currently being offered in the market.	Improving CDI's grievance process may increase consumers' power in dispute resolution.
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C. Functional Regulation With Each Agency Having Regulatory Jurisdiction Over Certain Aspects of Health Insurers and Health Care Plans

It is apparent that DMHC and CDI have somewhat different strengths. DMHC's comparative strengths are its exclusive focus on health care, the development of a consumer grievance program with specified timelines for dispute resolution, administration of the independent medical review system, its quality of care monitoring, and its consumer health care education programs. CDI's comparative strengths are its financial surveillance programs, its ability to respond to consumer questions and complaints from an insurance perspective, and its national connections to regulators in other states.

The State could benefit from each department's comparative strengths by adopting a functional approach to regulation. Under this model, each agency's strengths would be brought to bear in jointly or collaboratively regulating health insurance and health care service plans. For example, DMHC could take over *all* consumer grievance processes involving health insurance and health service plans, including the IMR system, and all quality of care and consumer health education programs (e.g., publication of quality report cards). In practice, this would mean that all health insurance calls would be handled by DMHC's hotline, DMHC would become responsible for quality of care monitoring of insurer-PPOs and EPOs,⁴ and DMHC would have to expand its consumer education reports to encompass all health insurance products offered by CDI insurers. At the same time, CDI would become responsible for conducting financial surveillance of all entities regulated by DMHC, perhaps upgrading the financial requirements applicable to health care plans from tangible net equity to risk-based capital. Presumably, both DMHC and CDI would

⁴ There is no need for, or ability to engage in, quality of care monitoring of pure indemnity health insurance since there is no limited panel of providers offering health services.

have some responsibility for analyzing and approving new policies and products, since policy approval involves both health care and financial issues.

Functional regulation could be accomplished either by statutes that specifically assign regulatory functions to each agency or by agreements between the two agencies which allocate regulatory functions (perhaps pursuant to statutory authorization, if necessary). An example of functional regulation by contract is the agreement reached between CDI and DMHC to have DMHC administer the IMR system. Similar agreements could be reached with respect to the hotline, financial surveillance and quality of care. This sort of consultation and collaboration is nothing new. Indeed, Section 1342.5 of the Health & Safety Code already requires that the DMHC's "director shall consult with the Insurance Commissioner prior to adopting any regulations . . . for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Health Care."

The most significant difficulty with this approach is that regulatory functions are not so neatly compartmentalized. Within both agencies, there is a substantial amount of communication between functional units. The hotlines in both agencies serve as the front-line eyes and ears of the agency. Systematic problems identified by the hotline may be passed along to the financial surveillance, market conduct, and enforcement divisions. Similarly, field examinations by financial surveillance and market conduct divisions may generate inquiries to the hotline or to product approval divisions. Thus, a functional regulatory approach would require a much greater degree of collaboration between the two agencies than currently exists, and perhaps more collaboration than can reasonably be expected. The potential difficulties may suggest the need to attempt a few collaborative ventures on a pilot project basis to assess the administrative feasibility of this approach.

Functional regulation would tend to result in a natural equalization of consumer and other protections since, within each regulator's sphere of responsibility, there would be strong pressure to treat like companies and like products equivalently. This is probably one of the strongest features of a functional regulation approach since the equalization of regulation should occur naturally simply as a result of the regulatory structure.

A final problem should be considered. If the Director of DMHC and the

Insurance Commissioner were both appointed by the Governor, the State could be assured of some reasonable degree of cooperation between DMHC and CDI. However, the Insurance Commissioner is an independently elected official, and even if the Insurance Commissioner and the Governor are of the same political party, there is no assurance that their views regarding health care regulation will be aligned. Differences in viewpoint are likely to be greater if the Governor and Insurance Commissioner are of different political parties. Such differences may, in the long run, undermine a functional regulatory approach since there are, as noted above, significant interactions between different regulatory activities.

The pros and cons of functional regulations may be summarized as follows:

Stakeholder	Pros	Cons
Consumers	<p>Single hotline for health insurance operated by DMHC pursuant to Knox-Keene Act's grievance process.</p> <p>Quality of care for all health insurance regulated by DMHC, one of its areas of expertise.</p> <p>Strengthening solvency of health care plans by subjecting plans to CDI financial jurisdiction reduces likelihood of interruption in services.</p> <p>Joint regulation of product approval ensures that health care issues taken into account in designing health insurance products.</p> <p>Minimal impact upon products currently being offered in the market.</p>	<p>Maintaining two regulators risks inconsistent regulation and confusion notwithstanding functional distinctions.</p>
Providers	<p>Strengthening solvency of health care plans by subjecting plans to CDI financial jurisdiction reduces likelihood of difficulty in payment.</p> <p>Minimal impact upon products currently being offered in the market.</p>	<p>Maintaining two regulators risks inconsistent regulation and confusion notwithstanding functional distinctions.</p>

Chapter III. Options for Reform of Regulatory Jurisdiction

Plans	Minimal impact upon products currently being offered in the market.	Plans required to subject themselves to a new regulator and be subject to two regulators. More intrusive quality of care regulation with respect to PPOs or POSs may increase costs without commensurate improvement in quality of care. Strengthening solvency standards increases costs (but arguably benefits plans in the long run).
Insurers	Improving CDI's grievance process and hotline performance helps insurer / insured relationship. Minimal impact upon products currently being offered in the market.	Insurers required to subject themselves to a new regulator and be subject to two regulators. Improving CDI's grievance process and hotline performance may increase consumers' power in dispute resolution.

D. DMHC Jurisdiction Over All Health Insurance

The most sweeping change would move all health insurance currently regulated by CDI to the jurisdiction of DMHC, encompassing all types of disability insurance including major medical, PPO and EPO products and all specialty disability policies. The simplest and cleanest way of accomplishing the regulatory transfer would be to add language to the Insurance Code prohibiting an insurer from offering a "health insurance" product where benefits reimburse the insured for utilization of health care services.⁵ Alternatively, language could be added prohibiting an insurer from offering major medical coverage, thereby leaving within CDI a grab-bag of specialized disability policies. In either event, the great bulk of CDI's jurisdiction would be

⁵ This approach would leave within CDI's jurisdiction disability insurance products that do not qualify as health insurance. For example, some companies offer health disability income policies that pay the insured a daily sum to offset income loss during periods of health-related disability. This type of product should remain within CDI's jurisdiction since, while health related for insurance purposes, the benefits have nothing to do with the health care system.

transferred to DMHC.⁶

Under this approach, insurance companies which desire to continue offering health insurance or major medical coverage would probably have to transfer these products to separate subsidiaries which would have to become licensed by DMHC and be subject to DMHC jurisdiction. While it might technically be possible for an insurer to offer health insurance products directly and be regulated by both CDI and DMHC, the complexities of this approach strongly suggest that requiring separate health subsidiaries is the preferable alternative, both for the company and the regulators. For example, it might technically be possible to adjust the premium tax law and the bank and corporations tax law to make an allocation between an insurer's non-health products (which would be subject to the premium tax) and an insurer's health insurance products (which would be taxed under the bank and corporations tax provisions). However, it would be far simpler to have separate corporate entities where the insurer would be subject to the usual premium tax, and the health insurance subsidiary would be subject to the bank and corporations tax.

Requiring health insurance products to be offered by a separate subsidiary would simplify the regulatory process and reduce regulatory duplication. It would not entirely separate CDI's and DMHC's regulatory jurisdiction, of course. For example, CDI's risk-based capital analysis would still include within its scope an assessment of the risks associated with the health insurance subsidiary, and DMHC would also examine the subsidiary for solvency. Nevertheless, requiring an insurer to form a

⁶ The proposal in the text contemplates that the jurisdictional transfer would mean that health insurance products would be regulated pursuant to Knox-Keene, with appropriate amendments, instead of pursuant to the Insurance Code. Theoretically, it would be possible to give DMHC jurisdiction to enforce the Insurance Code with respect to health insurance issues. However, the potential for regulatory conflict presented by this approach is enormous, and it would require DMHC to develop a duplicative expertise in the Insurance Code and regulations promulgated by CDI.

separate health subsidiary seems like the best way of implementing this proposal.

Moving all health insurance products to DMHC should significantly reduce the confusion that consumers and providers have regarding whom to call for help with health insurance problems. Even with such a move, however, we can anticipate that CDI will continue to receive a significant number of calls regarding health care problems, if only because many consumers who have problems with their health insurance are more likely to think the Department of Insurance is responsible than some other state agency. However, if the regulation of all health insurance products has been transferred to DMHC, it should be easier than it is now for CDI quickly to determine that a consumer call needs to be transferred to DMHC.

Transferring jurisdiction to DMHC would also make it much more likely that benefits would equalize over time and that there would be uniform administration of quality of care programs, claims practices, and financial solvency regulation (either pursuant to the existing net equity requirements or, perhaps, a heightened risk-based capital approach that arguably should apply to all health care plans). This equalization would happen naturally as the consequence of a single regulator responsible for fairly treating similar companies and similar products pursuant to similar regulatory practices.

There are certain negative consequences associated with transferring all health insurance products to DMHC. First, many of the products transferred will be pure indemnity health insurance where there is virtually no issue about quality of care, and the primary regulatory responsibility is solvency protection and claims handling. CDI's comparative strengths are its financial surveillance and claims handling divisions, both of which draw upon national standards set by the National Association of Insurance Commissioners. Thus, moving these products to DMHC is likely to result in a weakening of the State's regulatory authority over indemnity health insurance products, unless DMHC makes substantial changes in its operations (e.g., adopting a risk-based capital standard for solvency protection, adopting NAIC's claims handling standards and, possibly, joining NAIC to maintain its national perspective on insurance issues).

Second, transferring jurisdiction from CDI to DMHC will have an impact on the State's revenues. As noted at the end of Chapter II, although it is difficult to estimate the precise impact, it appears that a transfer of jurisdiction is likely to result in a

decrease of approximately \$50 million annually in tax revenues. This is a significant decrease in revenues and will be a concern to both the Governor and the Legislature.

Third, because of the Knox-Keene Act's requirement that all plans offer basic medical services, unless Knox-Keene is amended to permit greater flexibility in benefit design, consumers may lose certain specialized health insurance products that now exist and serve special needs. If health insurance products are transferred to DMHC, serious consideration should be given to exempting indemnity health insurance products offered by subsidiaries of insurers from some of the requirements of the Knox-Keene Act.

Fourth, because the Knox-Keene Act requires *direct* contracting with providers, whereas the Insurance Code permits insurers with PPO and EPO products to use leased networks of providers, the costs associated with PPOs and EPOs currently regulated by CDI is likely to increase if they are subjected to a direct contracting requirement. Thus, if regulatory jurisdiction is transferred, some consideration should be given to amending Knox-Keene to permit the use of leased networks.

Fifth, because of the costs associated with creating health insurance subsidiaries and the hesitation and fear some insurers have expressed about subjecting themselves to an additional regulator and to new administrative requirements (e.g., the requirement that all books and records be located in California), a certain percentage of insurers are likely to withdraw from the market. There is no way of accurately predicting how many insurers would withdraw from the health insurance market, but the risk of such withdrawal is quite real. Many insurers offer health insurance products as part of a package of other insurance products (e.g., health benefits may be offered at the same time as life insurance, and health insurance is sometimes offered to businesses as part of a package of workmens' compensation and other commercial insurance). When given the choice of creating a separate subsidiary to offer a mono-line product (a concentration of risk that increases the likelihood of failure), establishing a greater California corporate presence to offer health insurance, and simply withdrawing from the health insurance market in California, some companies will undoubtedly choose to withdraw. This will reduce consumer choice, reduce competition and result in an additional decrease in revenues generated by the premium tax.

Stakeholder	Pros	Cons
Consumers	<p>Insureds and enrollees have only one regulator to contact for questions or complaints.</p> <p>Quality of care for all health insurance regulated by DMHC, one of its areas of expertise.</p> <p>Should have more consistent application of statutes and regulations.</p>	<p>Initially, DMHC may have less expertise and experience than CDI in handling pure insurance-related questions.</p> <p>Unless Knox-Keene Act amended, consumers may lose some flexibility in products being offered.</p> <p>Unless Knox-Keene Act amended, solvency protections for transferred insurance products will be weakened (both diagnostic protections and protections in the event of insolvency).</p> <p>Unless Knox-Keene Act amended, costs related to transferred PPOs and EPOs may increase because of direct contracting requirement under Knox-Keene.</p> <p>Some insurers with PPOs and EPOs may leave the market.</p> <p>Some consumers are likely to lose existing providers during transition.</p>
Providers	<p>Single regulator should result in more consistent application of statutes and regulations.</p> <p>Greater simplicity in contacting single regulator with questions or problems.</p>	<p>Unless Knox-Keene Act amended, leased networks will be forbidden, and providers will have to renegotiate contracts (probably with fewer PPOs).</p> <p>Possibility of interrupting existing patient relationships during transition.</p> <p>Unless Knox-Keene Act amended, solvency protections for transferred insurance products will be weakened (both diagnostic protections and protections in the event of insolvency).</p> <p>Some companies currently regulated by CDI may leave the market, reducing competition for providers.</p>

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Plans	<p>Uniform regulation applicable to all health insurance will ensure level playing field.</p> <p>Some benefit to those few companies offering both CDI and DMHC regulated products.</p>	<p>Dramatic increase in DMHC's regulatory jurisdiction over insurance products may interfere with DMHC's attention to health care service plans.</p>
Insurers	<p>Uniform regulation applicable to all health insurance will ensure level playing field.</p> <p>Likelihood of smaller effective tax rate.</p>	<p>Insurers probably must spin-off health insurance products into subsidiary and then seek new license from DMHC.</p> <p>Insurers will lose the national advantages of relatively uniform insurance regulation.</p> <p>Insurer PPOs and EPOs will no longer be able to use leased networks unless Knox-Keene Act amended.</p> <p>Probably have to relocate claims processing and administration to California to be subject to DMHC jurisdiction.</p> <p>Interfere with ability to market health insurance as a package of insurance products.</p>

E. DMHC Jurisdiction Over All EPOs and/or PPOs

As noted above, transferring jurisdiction over all health insurance from CDI to DMHC would place within DMHC's jurisdiction pure indemnity health insurance policies. The regulation of pure indemnity health insurance draws upon all of CDI's existing expertise; by contrast, DMHC is comparatively ill-equipped at present to regulate pure indemnity policies, and there do not seem to be very many advantages to transferring jurisdiction over pure indemnity policies from CDI to DMHC since quality of care issues are at a minimum with respect to pure indemnity products. As a middle ground, the final option discussed is transferring jurisdiction over EPOs and/or PPOs from CDI to DMHC.

As described above, EPOs have one of the main characteristics of health care plans: restricted consumer choice of providers. When the Legislature amended the Insurance Code to authorize EPOs, it recognized the need to adopt some minimum quality of care requirements to assure that the restricted provider choice did not substantially impair an insured's access to appropriate health care. Ins. Code § 10133(d). However, these minimum requirements do not go beyond requiring contracts between insurers and EPOs to contain certain specified quality of care programs. CDI itself does not review these contracts from a health perspective, and CDI does not regulate, either directly or indirectly, EPOs.

To some extent, EPO products offered by insurers appear to be mini-HMOs. Admittedly, the contracts between an insurer and EPO may not attempt to transfer risk to the EPO (e.g., through capitation or risk-adjusted reimbursement) and must simply reflect a discounted fee-for-service, and this helps to distinguish EPOs from HMOs. Thus, quality of care in an EPO is not as likely as in a plan to be influenced by economic incentives to reduce or restrict care. However, the restricted access to providers plainly creates concerns about the overall quality of care offered to EPO consumers.

Jurisdiction over EPOs could be transferred from CDI to DMHC by repealing subdivisions (c) and (d) of Section 10133 of the Insurance Code, which currently authorize insurers to enter into EPO arrangements, and adding language to the Health & Safety Code authorizing DMHC-regulated entities to offer EPO products. With these statutory changes, insurers would no longer be permitted to offer an EPO product, and an insurer which wished to offer such a product would probably need to create an EPO-subsiary which would be subject to DMHC's regulatory jurisdiction.

Jurisdiction over PPOs raises slightly different issues. As already noted, quality of care issues are generally less prominent in a PPO context than in an EPO or HMO context, and the fee-for-service nature of PPOs makes disputes over medical necessity and experimental and investigational treatments less likely to arise. Arguably, in light of the fee-for-service characteristic of PPOs, *all* PPOs should be within the jurisdiction of CDI instead of within the jurisdiction of DMHC since PPO products seem to share more in common with providing indemnity than with providing health care services. At this point in time, however, that is clearly not an option worth exploring since the largest DMHC-regulated entities offering PPO products actively sought to be regulated by DMHC instead of by CDI, and both the Legislature and DMHC has acquiesced.

This leaves us with a situation where seemingly identical products are regulated by two different agencies, agencies which may not share the same regulatory philosophies (particularly since the Insurance Commissioner is an independently elected official who may or may not share the same perspectives as the Director of DMHC, who is appointed by the Governor). The only real difference is that PPOs offered by entities that already hold a license from CDI are regulated by CDI, and PPOs offered by entities already regulated by DMHC will be regulated by DMHC. This is a difference largely grounded in a long history of efforts by certain entities to avoid being regulated by CDI.

Jurisdiction over PPOs could effectively be transferred from CDI to DMHC by repealing subdivision (b) of Section 10133 of the Insurance Code, which currently authorizes insurers to enter into PPO arrangements, and by adding a statute to the Health & Safety Code authorizing DMHC-regulated entities to offer PPO products. With these changes, insurers would no longer be permitted to offer a PPO product, and an insurer which wished to offer such a product would probably need to create a PPO-subsubsidiary which would be subject to DMHC's regulatory jurisdiction.

The disadvantages to transferring jurisdiction over EPOs and/or PPOs from CDI to DMHC are essentially the same disadvantages cited above in discussing a transfer of all health insurance to DMHC. First, many of the issues that arise in the context of EPOs and PPOs are pure insurance issues (e.g., coverage and claims handling questions), and a regulatory transfer may actually result in diminishing the current level of enforcement. Second, there is likely to be an overall decrease in tax revenues, albeit of a smaller amount than if all health insurance was transferred to DMHC. Third, Knox-Keene would probably have to be amended to permit continued use of leased networks. Finally, some insurers who are offering health insurance as an ancillary part of a bigger package of insurance products may simply stop offering health insurance to avoid the inconvenience and expense of becoming subject to DMHC's jurisdiction.

Stakeholder	Pros	Cons
Consumers	Insureds in PPOs and EPOs and enrollees have only one regulator to contact for	CDI jurisdiction over indemnity health insurance may still create confusion over

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	<p>questions or complaints.</p> <p>Quality of care for all PPOs and EPOs will be regulated by DMHC, one of its areas of expertise.</p> <p>Should have more consistent application of statutes and regulations with respect to PPOs and EPOs.</p>	<p>who is the proper regulator.</p> <p>Unless Knox-Keene Act amended, solvency protections for transferred insurance products will be weakened (both diagnostic protections and protections in the event of insolvency).</p> <p>Unless Knox-Keene Act amended, costs related to transferred PPOs and EPOs may increase because of direct contracting requirement under Knox-Keene.</p> <p>Some insurers with PPOs and EPOs may leave the market.</p> <p>Some consumers are likely to lose existing providers during transition.</p>
Providers	<p>Single regulator should result in more consistent application of statutes and regulations with respect to PPOs and EPOs.</p> <p>Greater simplicity in contacting single regulator with questions or problems with PPOs and EPOs.</p>	<p>CDI jurisdiction over indemnity health insurance may still create some confusion over who to contact.</p> <p>Unless Knox-Keene Act amended, leased networks will be forbidden, and providers will have to renegotiate contracts (probably with fewer PPOs).</p> <p>Possibility of interrupting existing patient relationships during transition.</p> <p>Unless Knox-Keene Act amended, solvency protections for transferred insurance products will be weakened (both diagnostic protections and protections in the event of insolvency).</p> <p>Some companies with PPOs and EPOs currently regulated by CDI may leave the market, reducing competition for providers.</p>
Plans	<p>Uniform regulation applicable to all PPOs and EPOs will ensure level playing field with similar products.</p> <p>Some benefit to those few companies</p>	<p>Increase in DMHC's regulatory jurisdiction over insurance products may interfere with DMHC's attention to health care service plans.</p>

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	offering both CDI and DMHC regulated products.	
Insurers	<p>Uniform regulation applicable to all PPOs and EPOs will ensure level playing field.</p> <p>Likelihood of smaller effective tax rate.</p>	<p>Insurers probably must spin-off PPO and EPO products into subsidiary and then seek new license from DMHC.</p> <p>Insurers will lose the national advantages of relatively uniform insurance regulation.</p> <p>Insurer PPOs and EPOs will no longer be able to use leased networks unless Knox-Keene Act amended.</p> <p>Probably have to relocate claims processing and administration to California to be subject to DMHC jurisdiction.</p> <p>Interfere with ability to market PPO and EPO products as part of a package of insurance products.</p>